COMMUNITY LIVING DURHAM NORTH

MEDICATION ADMINISTRATION

Policy No: B-11 (Service Delivery)

Effective Date: May 1, 2007
Last Revision: September 28, 2009
Last Review: November 9, 2021

Rationale:

To reinforce our commitment to consistent high quality support, and to ensure that people receiving service are assisted to take prescribed and over-the-counter medications in the safest possible way.

Policy Statement:

Employees of the Association are required to administer and supervise the administration of medications. Therefore, a comprehensive set of procedures are developed to ensure the well-being of supported persons and to provide necessary direction for staff.

These procedures will be based in the following principles:

- The assurance of each person's health and safety will be of primary importance in monitoring, storing and administering medication.
- Each person has a right to regular medication reviews by his/her physician, and medication should be reduced or eliminated, if possible, whenever it is found to be unhelpful or unnecessary.
- The person is also entitled to be informed as much as possible about the medication they are receiving, and to be as involved as possible in the administration of the medication.
- Employees have a right to be appropriately trained in the handling and administration of medication.

Approved by: *Larry Leonard* Date: *September 28, 2009*
for the Board of Directors

COMMUNITY LIVING DURHAM NORTH

MEDICATION ADMINISTRATION

Procedure No: B-11-1	Effective Date: April 1, 2010
Staff Training in Med Administration	Last Revision: May 14, 2021
	Last Review: November 9, 2021

- CLDN provides mandatory training in medication administration and this occurs at the very outset, as part of our multi-day Agency Orientation.

- When it is found that an existing employee requires re-training, he or she will be enrolled in this particular segment of a scheduled Orientation session.

- Team Leaders or designate, will perform regular audits of how medications are administered. Using a prescribed checklist, the Team Leader or designate will select one team member and will observe that person's complete Medication Administration routine. Completed checklists will be reviewed by Managers and sent to Human Resources.

- These audits will not be random; if the team includes a new and inexperienced member, Team Leaders will give precedence to his or her training needs, and if necessary return to them in consecutive audits. HR will assist in holding Team Leaders accountable for the frequency and regularity of their Medication Administration audits.

Procedure No: B-11-2	Effective Date: April 1, 2010
Ordering and Receiving Medications	Last Revision: January 15, 2022
	Last Review:

- The responsible support staff (or Home Provider) will ensure medication prescriptions are promptly delivered to the person's preferred pharmacy so the prescription can be filled.

- Staff will request a photocopy of the prescription from the Pharmacist and staple the prescription to the AIMS Clinical.

- Typically, the pharmacy will deliver newly prescribed medications. If for some reason delivery cannot be made within 24 hours of ordering, staff must pick up the medication.

- In Residential locations all prescription medications must have an accompanying Health Information Sheet provided by the pharmacist. It is to be kept in the Medication Binder in the appropriate section, according to the index, for the duration that the medication is being used.

- Long standing prescriptions will require physician's approval on an annual basis, minimally. The Team Leader will be responsible for ensuring medications are regularly

reviewed and reordered by the prescribing physician, on time. The current medication label will record the number of weekly refills (REF) left for a particular medication. This is typically completed during the person's annual health review but may be required at other times. For example; if the medication is only ordered for 30 days, follow up with the doctor will need to occur sooner. The pharmacist can provide a *Medication Order Record* that summarizes all of the current medications to present to the prescribing physician for review.

- Medications come in a variety of forms such as pills, tablets, liquids, suppositories, creams and sprays. Each will have a specific route of administration such as ingestion, inhalation, insertion (in the case of suppositories) or external application (e.g. to the affected skin area).

- Regular tablet and capsule medications, that are typically taken daily, are dispensed into 7-Day Bubble Packs by the pharmacy and are delivered on the same day each week. Medications that are highly sensitive to moisture and light may be dispensed separately into foil packaging and inserted into an outside case containing the original label.

- A 30-day Bubble Pack is mostly used for PRN Medications (both Behavioural Support PRN's and Treatment PRN's). These medications are considered usable for up to one year from the pharmacy's dispensing date, unless otherwise stated on the medication label. Staff will ensure that new bubble packs are ordered before medication expires or the PRN medication supply becomes too low.

- Prescription creams that are compounded (two or more medications mixed together by the pharmacist) are considered useable for three months after the dispensing date.

- Prescription medication will only be given to the person for whom it was prescribed and will not be shared with other persons.

- Other medications/topical treatments that are classed as <u>over the counter</u> products such as Acetaminophen (Tylenol) are purchased and available for people as stated in their individual PRN Treatment Guidelines.

- Stock bottles (i.e. bottles for shared use) are permitted for over the counter PRN medications such as acetaminophen and gravol. When preparing and administering such medications, staff must wash their hands and take other normal hygienic precautions in order to not contaminate the stock medicine. This procedure involves carefully pouring the correct number of pills into the sterile lid of the stock medication bottle without touching either the pill(s) or the inside of the lid. When the correct number of pills is in the lid they are poured into a clean medication cup. Finally, the lid is secured on the stock bottle. This procedure keeps both the pills in the bottle and the inside of the lid sterile.

- *Medication Administration Records* are prepared by the pharmacist and delivered monthly. These *Medication Administration Records* contain all the current prescribed medications for each person. The Team Leader or designate will liaise with the doctor and pharmacy to personalize a *Medication Administration Record* for each person supported. In every case, however, the pharmacy must be provided with a written script.

- The Team Leader or designate will oversee the process of receiving monthly *Medication Administration Records*. The process includes the following steps:

a. Start at the top of the current month's *Medication Administration Record* and match the prescription word for word to the next month's *Medication Administration Record.*
b. Ensure that all regularly prescribed medication stated on the next month's *Medication Administration Record* is actually available.
c. Ensure that all medications received have clearly labelled expiry dates.
d. Ensure that all doctor-approved PRN Medications, both prescribed and over-the-counter, are on hand and have not passed their expiry date.
e. Additional information and ink highlights may be added to individual *Medication Administration Records* to clarify and stress important information such as the person's name, special administration instructions or times of administration.
f. Any discrepancies are reported to the pharmacy for clarification.

- All staff must be competent to receive medication into the home or program and check it for accuracy. This process includes the following steps:

  a. Match the prescription inscribed on the *Medication Administration Record* word for word to the inscription printed on the label of the medication container.

  b. Next, check that the medication in the container is correct; i.e. matches what is on the label and *Medication Administration Record.* Sign and date the top right hand corner of all bubble packs to signify the medication has been checked.

  c. When foil packaging is used, the staff receiving medications will use a black sharpie marker to number each foil blister for administration as prescribed, and will affix a blank label on the reverse side of the original label, on the outside container, for the purpose of tracking the administration of the medication.

  d. Any discrepancies in the dispensed medications and/or the Medication Administration Records must be promptly reported to the pharmacy.

  In the case of 7-day bubble packs, the staff person receiving the medication from the pharmacy will:

  a. Start with the first drug listed on the current *Medication Administration Record.*
  b. Match the prescription on the *Medication Administration Record* word for word to the inscription on the label of the 7-day Bubble Pack.
  c. Identify the pill by colour, size and markings as listed on the label. Ensure the identified pill(s) are inserted into each corresponding bubble.
  d. If everything is in order with respect to the first drug included in the Bubble Pack, draw a diagonal line (\) from the top of the first day of administration to the bottom of the 7^{th} day of administration. The act of drawing the diagonal line signifies that this specific medication is accounted for in the 7-day Bubble Pack.
  e. Repeat for all other medications in the Bubble Pack.
  f. Sign and date the right hand corner of the actual 7-day Bubble Pack to signify that all medications have been received accurately.
  g. Report any discrepancies to the pharmacy.

- When medications are added or discontinued, or when dosages are increased or decreased, the pharmacist requires a written prescription or a verbal confirmation direct from the prescribing physician, in order to keep the *Medication Administration Record*

(MAR Sheet) accurate. As these changes are made, staff will take the appropriate 7-day Bubble Pack back to the pharmacy to have them updated. 7-Day Bubble Packs can only be opened and re-sealed by the pharmacist. If for some reason it is not possible to have the bubble packs updated by the pharmacist, staff will carefully remove the discontinued or withheld medication, at each medication administration time (do not go forward in time to adjust the contents of other bubbles).

- As of this revision (January 2022), the AIMS database is in use and, for people receiving residential service, it will facilitate the tracking of medications and the development of medication histories. Staff will use the database daily to record and track medication changes ordered by prescribing physicians. They will also use the database to record all medication incidents pertaining to all supported people.

- As of November 2016, people receiving ODSP have only to present their Ontario Health Card to receive coverage for most medications.

- At age 65, provincial income support ceases. The supported person or staff on their behalf must apply a year in advance for federal benefits (OAS & GAINS). But the affordability of medication remains a provincial responsibility. People turning 65 (or the staff who support them) must apply to the Ministry of Health and Long Term Care, Ontario Drug Program, to obtain the Co-Payment Drug Benefit. A letter from the Ministry of Health and Long Term Care will confirm of the benefit, which will be activated as soon as the letter is presented to the pharmacy. Eligibility will at that point be connected to the person's health card. Presentation of the card, thereafter, will entitle the person to prescription medication at a reduced cost. The original letter will be kept and maintained as part of the person's service record.

- People receiving support will be encouraged to participate in any of these steps if they are able to do so. He/she might also take ownership of one or more of these steps, but in this case his competence must first be demonstrated. The degree of his ongoing involvement must be clearly documented in his Personal Support Plan, and periodic oversight must be provided.

Procedure No: B-11-3	Effective Date: April 1, 2010
Administering Medications	Last Revision: April 15, 2019
	Last Review: November 9, 2021

Notes: The following does not apply to people who do not require support in this area and who self-administer their medication. See procedure B-11-13.

Respite staff should also refer to Policy/Procedure B-13-4 Medication Authorization.

- All medications will be locked in a cupboard or in another container that is large enough for orderly storage.

- Medications that require refrigeration are stored in a locked box in the fridge.

- The location where medications are stored and how to access the medications will be documented in each location's Program Information Binder.

- Staff will confer at the beginning of each shift and one person will assume responsibility for administering all medications, or at least all medications in a particular time slot. This will eliminate confusion and therefore mistakes.

- One staff on each shift must insert his name (printed) on the *Medication Status Record* (form C-7). It is then the responsibility of this designated staff to ensure that medication administered on the previous shift was done so accurately, and he or she must confer with the designate on the next shift to ensure that medication was prepared and administered accurately on their own shift. Essentially, staff "A" working 8-3 will check the work of Staff "C" who worked the overnight. Staff "B" arrives for their shift at 3 p.m. and will check the medication completed on Staff "A's" shift. Neither Staff "A", "B" or "C" need to be the employee preparing and administering the medication; they need to check the MAR sheets and medication containers/bubble packs to ensure that all medication was given and all documentation was properly completed.

- Staff must wash their hands and clear an appropriate area prior to beginning the medication administration routine.

- Medication is to be administered respectfully and individually, one person at a time.

- Staff will start at the top of the *Medication Administration Record* and gather the correct medication needed for that person.

- 7-day Bubble Packs are regular medications grouped together in separate plastic bubbles; the contents of each bubble to be given in a specific time period. Although each medication is listed separately on the *Medication Administration Record,* the space outlined indicating Compliance Pack Medications will be the place to document the preparation and administering outcome for all of those medications.

- Ensure you have the correct container or package by checking its label against the *Medication Administration Record*. Then, verify the five (5) "Rights to Medication Administration:"

    1. Person's name – The name must be located and matched three times (1) on the medication label (2) the picture located at the front of the person's medication index (3) the name inscribed on the *Medication Administration Record.*
    2. Medication name – match the name of the drug on the *Medication Administration Record* to the name of the drug on the container or package.
    3. Dosage/Strength - match the dosage and strength inscribed on the label to the dosage/strength shown on the *Medication Administration Record.*
    4. Time – match the time inscribed on the label to the time shown on the *Medication Administration Record.* Medication can be given up to one hour before, or up to one hour after, the prescribed time, unless otherwise determined by the person's physician or pharmacist. Any special time considerations will be noted on the *Medication Administration Record.*

5. Route - match the route (for administration) indicated on the label to the instruction provided on the *Medication Administration Record.*

- Double check the five (5) "Rights to Medication Administration" before proceeding to administer the medication.

- When using the 7-day Bubble Pack, the bubble containing the correct medication for the corresponding time and date can be torn off, opened and used as a medication cup. Prior to disposing of the now empty bubble, and the perforated segment containing it, obliterate the person's name, etc. with a magic marker.

- When a foil pack is used for daily medication, the pharmacy may have separated the blisters and placed them in a 7-day bubble. If not, B-11-2 *Ordering and Receiving Medications* provides a numbering system to start and to track the dispensing of these medications.

- When a foil packed medication is used for PRN medications, the blank label affixed to the package will enable staff to date and initial each medication dispensed. When using a 30-day blister pack (those used for PRN Treatment and Behavioural Support Medications), staff will always begin by using the medication in the blisters consecutively, from 1 to 30, and enter their initials and the date prepared in the appropriate space on the back of the blister.

- In all cases, staff will prepare the medication using a medicine cup, holding it below the blister pack/foil pack. Push the appropriate blister on the blister pack to force the pill(s) down into the cup that is held below it.

- Check that all the medication has been prepared. Sometimes pills can be stuck in the bubble pack material. Make an ink dot (•) in the appropriate cell on the *Medication Administration Record.* The ink dot signifies that the correct medication has been prepared on a particular day, and in a particular time slot. Continue until all medications for the person, in the time slot, have been prepared.

- Administer according to the person's preference. For example; pour the pills into the person's hand or hand the medicine cup to him/her. Ensure that the medication is ingested.

- After all medications have been administered, staff will initial the *Medication Administration Record.* In the case of a refusal, or a spoiled pill, or another development that requires explanation, refer to the key at the bottom of the *Medication Administration Record* and use the appropriate symbol for recording purposes. Medication refusals are followed up with an incident report and a service activity documented on AIMs.

- Ensure the "6th Right" - that all documentation is completed correctly.

- Medications must be administered within one hour on either side of the specified dosage time. Failure to comply with the one-hour window will be considered a medication error and will be dealt with in accordance with protocol (see B-11-8, *Medication Incidents*). When people are planning to be out in the evenings beyond their regular administration times, staff need to plan ahead and prepare medications to take with them. Exceptions will be made if the person is out during the evening and their medication is not available to them; in these cases, the last dose of the day can be delayed beyond one hour.

- When medication containers are ready to be discarded, all information on the label should be obliterated, prior to disposal; i.e. the person's name and the doctor's name.

Procedure No: B-11-4	Effective Date: April 10, 2019
Administering Alternative Medication	Last Revision:
	Last Review: November 9, 2021

- In some cases, people and/or their guardians choose to try alternative medication(s) to alleviate their ailments. In these situations, a Certified Naturopath/Homeopath will prescribe the alternative medication(s) and complete form C-28 *Non Prescription/ Alternative Medication* in its entirety.

- Form C-28 Non Prescription/Alternative Medication includes:

    - The name of the alternative medication, along with ingredient list
    - Methods of administration, dosage and times
    - Reason/purpose of alternative medication
    - Possible side effects
    - Storage instructions

- This form is signed by the supported person and/or their guardian and will act as consent for Community Living Durham North to administer the alternative medication.

- Staff will document the administration of the alternative medications on form C-29 *Community Living Durham North Medication Administration Record,* which is located in the medication binder under the supported person's section.

Procedure No: B-11-5	Effective Date: April 1, 2010
Administering P.R.N. Treatment Medications	Last Revision: October 27, 2023
	Last Review:

- PRN drugs are those given on an "as needed" basis in response to a particular sign or symptom. Medications used to treat everyday ailments such as headaches, coughs and constipation are listed on the person's *PRN Treatment Guideline* (form C-22).

- There should be a doctor's standing order in place for every PRN Treatment. On the basis of the doctor's standing order for an over-the-counter medication, the Team Leader or designate, will prepare the *PRN Treatment Guideline.* Form C-22 is a template that can be accessed for this purpose and then modified. The doctor who issued the order will review the form and be asked to sign off on it, as needed. The *PRN Treatment Guideline* is kept in the Medication Binder, in the section reserved for the person concerned, and will include at least these key particulars: name of drug, purpose, dosage/strength, and circumstances in which it is to be administered.

- Once the *PRN Treatment Guideline* is in the Medication Binder (signed or not signed by the physician) this by itself authorizes you to administer over-the-counter PRN's. We cannot deny people common remedies simply because it is not always possible to schedule a timely doctor appointment. The presence of the *PRN Treatment Guideline* in a person's medical binder indicates that the physician's standing order and signature will be sought during the person's next visit.

- If you believe that a PRN may be necessary, check the *PRN Treatment Guideline* to verify that the person's symptoms meet the stated criteria. If the criteria are met, then staff, regardless of job classification, may administer on their own initiative.

- When a PRN has been administered, staff will record the administration of the medication on the *Medication Administration Record*.

- In Residential locations all over-the-counter PRN Medications must have a Health Information Sheet that comes as a medication package insert provided by the maker of the medication. It is to be kept in the Medication Binder in the appropriate section, according to the index, for the duration the medication is being used.

- Sometimes doctors prescribe a PRN medication such as Lorazepam for an individual to take prior to an invasive medical appointment. Staff need to document the administration of this PRN in the AIMS clinical. The dosage and guidelines for administering this type of PRN are clearly defined on form C22-a "Medical Appointment PRN Instructions." Staff will monitor the person for side effects of the PRN and document their observations in the AIMS clinical.

Procedure No: B-11-6	Effective Date:	September 26, 2012
Administering Behavioural Support PRN's	Last Revision:	July 26, 2019
	Last Review:	November 9, 2021

- The use of a PRN as a behavioural support is an intrusive measure and a kind of restraint – a chemical restraint. It must be prescribed by a physician and tied to a clear protocol, developed in consultation with the physician, which defines the circumstances in which the medication is to be administered. The protocol must also address the need to monitor

and review the person's response to the medication. Our template for this protocol is Form B-28b *Behaviour Support PRN Instructions*.

- The protocol, or completed *Behaviour Support PRN Instructions,* is kept in the Medication Binder, in the section reserved for the person concerned. Its presence in the binder, signed by the physician, authorizes staff to administer the prescribed PRN.

- Behaviour Support PRN medication is typically dispensed, by the pharmacy, in a 30 day blister pack or a labeled container holding foiled blister packs. Staff will ensure that new blisters are ordered before the medication is considered expired or when the Behaviour Support PRN medication supply is low.

- When a PRN Behaviour Support medication has been administered, staff will record the administration on the person's *Medication Administration Record*. Staff will monitor the effects of the medication and record the information on *B-28h Behaviour Support PRN Monitoring Log.* These logs are used to report to the prescribing physician the effectiveness of the medication along with any observed side effects that may occur. It is

  always necessary to complete an AIMS *Restraint Incident Report.* The incident report will help to monitor how frequently, and in exactly what circumstances, psychotropics are being used.

- It is a requirement under Ont. Reg. 299/10 (Quality Assurance Measures) that the use of a PRN for behavioural purposes be accompanied by a Behaviour Support Plan (see policy *B-25 Positive Behavioural Support*) and that the use of the PRN medication be reviewed annually by the prescribing physician. The use of psychotropics must also by reviewed by the agency's Rights Committee on an annual basis (see policy *B-18 Rights Review Committee).*

Procedure No: B-11-7	Effective Date: April 1, 2010
Daily Inspection of Blister Packages	Last Revision: April 15, 2019
	Last Review: November 9, 2021

- Each day, there must be multiple re-checks to ensure that no medication error has occurred, and the check will be most effective if it is not done by the person who administered the last round of medications - our own errors tend to be the most difficult to spot.

- The result of these checks will be recorded on form C-7 *Medication Status Record.*

- In a small residential location, where there is only a single staff working, the staff is not required to check his own work at the conclusion of his shift. Instead, he or she will

check the work done on the previous shift and will do this as close as possible to his or her start time.

- In programs where there are typically two or more people working together, one staff will assume responsibility for checking the *Medication Administration Record* and bubble packs at the beginning of his shift to ensure medication status is okay with respect to the dispensing and administering of medication on the previous shift. Only this designated staff needs to sign in at the beginning of his shift on form C-7 *Medication Status Record*.

- The check involves a close visual inspection of the actual bubble pack to ensure that all medication that should have been given has at least been removed from the package. The next step is to look closely at the *Medication Administration Record* (MAR Sheet) in order to verify that the medication was administered and that there is a staff initial signifying that the medication was given. Alternatively, the visual check will confirm that the appropriate code number has been entered, i.e. #5 for "Hold" or #2 for "Medication Refusal."

- In the event of a discovered error, staff will enter "*NO*" on the *Medication Status Record*. Subsequent steps are as dictated in Procedure B-11-8, below.

Procedure No: B-11-8	Effective Date: April 1, 2010
Medication Incidents	Last Revision: September 26, 2012
	Last Review: November 9, 2021

- Each of the following constitutes a medication incident:
    a. Missed or forgotten medication (exceeding one hour either before or after the designated dosage time).
    b. Administering the wrong medication, an incorrect amount of medication or administering the medication via the wrong route.
    c. Administering a medication at the wrong time.
    d. Administering medication to the wrong person.

- In the event of a medication incident, of types (a) through (d), above, staff will follow the procedures in the order provided:

    a. In case of potential health risk, staff will seek medical advice (i.e. Pharmacy, Poison Control and/or the local Emergency Department).
    b. Contact managerial personnel as directed in Policy B-15 *Reporting and Emergency Response Systems.*
    c. Highlight the designated space on the *Medication Administration Record.*
    d. In the event of a discovered error, enter "*NO*" on the *Medication Status Record*.
    e. Complete an AIMS *Medication Incident Report.*

- Other kinds of Medication Incident, to which the response is different, are errors in procedure or documentation:

    a. An error in documentation has occurred if it is discovered that a medication was given but not initialled as having been given on the *Medication Administration Record*, or that the appropriate status was not entered.

    b. An error in procedure occurs whenever a person deviates from the step by step protocol for administering medication, as set forth in this policy. For example, in B-11-3, above, it states "Medication is to be administered respectfully and individually, one person at a time." Therefore, a staff who lines up several med cups and then begins to pop bubbles, belonging to multiple people, into these several cups, has made multiple errors which must be reported as such.
    Note that a deviation from procedure might occur for good reason. For example, it might be thought that a person would take his medication more readily if he was allowed more privacy, e.g. if staff put the med cup somewhere for him and then left the scene. However, B-11-3 requires you to "ensure that the medication is ingested." It would create an unsafe environment if individual staff were permitted to deviate from this policy at their own discretion. Therefore, it is a procedural error to deviate in this way, on one's own initiative, without consulting the rest of the team.

    But the very same action, if it is first given careful consideration by the whole team, can be approved by the Manager and documented in the individual's Personal Support Plan. At that point, it becomes an alternative strategy and will obviously not be construed as a Medication Incident.

- In the event of a procedural error as described above, the response is to complete an AIMS *Medication Incident Report*. The same incident report is completed in the event of a documentation error; additionally, staff will enter "*NO*" on the *Medication Status Record*.

- Finally, a "found pill" is also a Medication Incident. The pill is obvious evidence of an error; someone has not ingested their medication. But it may be impossible to determine when the error occurred, which supported person was affected or what staff were involved. Regardless, the response is to complete an AIMS *Medication Incident Report.*

- Information on medication errors is carefully collected, logged and analyzed. The primary purpose, of course, is to ensure that supported people are safe. The analysis of errors and error rates will be used to inform adjustments to this policy and to our training practices. Medication errors are disciplinable, but the Board and management of CLDN recognize that people will make mistakes. These mistakes must be quickly recognized and reported, and our error rate constantly monitored.

Procedure No: B-11-9	Effective Date: April 1, 2010
Packaging Medication to be Administered Offsite	Last Revision: January 30, 2017
	Last Review: November 9, 2021

- One staff will assume responsibility for packaging essential medication that needs to be taken with the person.

- Staff will ascertain the date and time of expected return. Staff should assess the possibility of an extended visit and provide additional medication accordingly.

- Where 7-day Bubble Packs with perforations are being used, the appropriate bubble(s) will be separated from the pack and given (still sealed) to the supported person, or to his family member, or to the designated staff person from another program, as appropriate,

- In the case of 30-pill bubble packs, generally used for Behaviour Support PRN medication or for antibiotics, staff will either provide the full 30-pill bubble pack or plan ahead and request that travel doses be dispensed by the pharmacy.

- Staff can take the 30-pill bubble pack back to the pharmacy and request as many travel doses as needed. The pharmacy will dispense the required pills from the 30-pill bubble pack into separate vials and label accordingly. The travel doses and bubble pack will be returned to the program. The travel doses will be numbered to the corresponding vacant bubble that it originally came from for tracking purposes. Vials can then be provided for visits with families, trips and other programs that the person attends. Notations will be added to the 30-day bubble card (e.g. "#1 travel dose given to family Jan 3, 2017") and initialed by the staff completing this action. An AIMS service activity is also required.

- Non-tablet medication such as topical creams, ointments, powdered medication, liquids, inhalers and injections will be sent in their original containers.

- Stock bottles of over the counter medication such as Tylenol will be supplied in the original container as needed.

- Once medications have been packaged, staff will place a dot in the appropriate cell(s) of the *Medication Administration Record* (i.e. one dot for each dosage, on each day that the person is expected to be away). After the person has left, when his medications become due, staff will refer to the key on the *Medication Administration Record* and enter the appropriate marking over top of the dot. Should the person come home early, staff will administer the packaged medications, and initial over top of the dot.

- Staff may assist the caregiver by providing a written *Medication Schedule,* form C-8. Staff are to review any information deemed necessary to assist the family (i.e. techniques to administer, possible contraindications).

- Staff will document in AIMS, via "Service Activity," that they have packaged medication for the person.

- After the visit, staff will check and secure any returning medication. If travel doses were returned, a corresponding note must be included on the 30-day bubble pack for tracking purposes. Any unused medication that was missed or refused while the person was away will be disposed of upon his return, according to B-11-10, below.

- If a person returns earlier than expected and does not return with their scheduled medication, staff will remove the required medication from the last bubble of the week or month and administer it at the scheduled time.

- The Team Leader or designate will subsequently replenish the supply, if needed.

- The Team Leader or designate will investigate travel requirements for medications when a supported person is planning out of country travel.

Procedure No: B-11-10	Effective Date: April 1, 2010
Prescription Changes and the Disposal of Unused Medication	Last Revision: June 15, 2017 Last Review: November 9, 2021

- When medications are added or discontinued, or when dosages are increased or decreased, the pharmacist requires a written prescription or a verbal confirmation directly from the prescribing physician, in order to keep the *Medication Administration Record* accurate. Staff will take the appropriate 7 Day Bubble Pack back to the pharmacy to have it updated. Attending staff are responsible for updating the medication list on the AIMS "Medication" tab.

- If this return to the pharmacy cannot happen immediately (perhaps it is closed) staff will deal with discontinuations by writing the letter "D" (for discontinued) on the *Medication Administration Record,* in the appropriate date column, and by drawing a red line through the row to the end of the month. A sticky label will be affixed to the bubble pack stating, for example, "do not administer the red Docusate Sodium, 100 mg, at 0800 tomorrow morning." Also, in this case, a reminder would be written to staff in the Program Calendar and the medication will be updated in the person's AIMS "Medication" tab.

- All unused and expired medications are collected in a medication disposal container and taken to the pharmacy on a monthly basis.

Procedure No: B-11-11	Effective Date: April 1, 2010
When a Medication is Missing, Damaged or Dropped	Last Revision: September 26, 2012
	Last Review: November 9, 2021

- Because a single pill is typically at issue, staff will call the pharmacy for a replacement. If it is not possible to obtain a replacement pill from the pharmacy, staff will ask the pharmacist if the medication can be safely skipped.

- If the medication cannot be skipped, staff are to refer to policy B-15 *Emergency Response and Reporting Systems*.

Procedure No: B-11-12	Effective Date: September 26, 2012
Narcotics and Controlled Substances	Last Revision: February 9, 2024
	Last Review:

- Prescribed medication may include medications classed as narcotics and non-narcotic controlled substances. These medications are monitored under Ontario Regulation 381/11 of the Narcotics Safety and Awareness Act 2010. Prescription narcotics are drugs commonly prescribed to relieve moderate to severe pain. Examples of common narcotics are acetaminophen with codeine (Tylenol 3) and oxycodone hcl with acetaminophen (Percocet). Under the Act, non-narcotic controlled substances include medications such as methylphenidate (Ritalin), benzodiazepines (Valium, Clozapam) and barbiturates (Phenobarbital). When these narcotic medications are in pill form, they must be packaged and labelled in a separate blister pack. If the medication is provided in any other package, like a bottle, staff must take the medication to the pharmacy to have it re-packaged into a blister pack.

- The above medications are known to be habit forming; therefore, they can be abused. Regulations require valid personal identification to be presented at the pharmacy when ordering or receiving these types of medications. The regulation also allows us as an organization to appoint a director to act as an "agent" on behalf of people we support. This would relieve staff of having to identify themselves at the pharmacy.

- When PRN Narcotic medications are prescribed as defined above, they must be double-locked, i.e. kept locked in their own individual container within the locked medication cupboard. Two staff together are required to perform a count twice daily (beginning of day and end of day) of the narcotic medication. This count will be documented on form C-33 "Daily Narcotic Medication Count" which includes the total count of medications and staff signatures. Form C-33 will be kept in the medication binder for as long as the narcotic medication is in use. In situations where there is only one staff on shift available to perform the physical count, this staff will need to complete form C-33 and email it to their Manager.

- Narcotic medications are typically ordered as a PRN medication to control pain and in response to a significant event. Nevertheless, when any narcotic medication is no longer required by a person, form C-25 *Disposal of Narcotic Medications* prepared by a staff person and taken with the medication to the pharmacy for verification that the medication has been accounted for and disposed of in a safe way.

- The original signed form is sent to the Program Manager who will verify its accuracy and attach it to the person's corresponding *Medication Administration Record.*

- The use of Cannabis products for relief of disorders like seizures or chronic pain issues that have not responded to conventional medical treatments is now an option for supported people. Cannabis is a controlled substance which needs to be carefully monitored and evaluated. Community Living Durham North will work closely with the prescribing physician/clinic to establish person-specific procedures for the receiving, storage, administration and disposal of this controlled substance.

Procedure No: B-11-13	Effective Date: June 30, 2011
Self-Administration of Medications	Last Revision: September 26, 2012
	Last Review: November 9, 2021

- It is common for people in Supported Independent Living to self administer, but regardless of people's circumstances, they should be encouraged to assume this responsibility if they have the capacity to do so.

- Capacity must first be ascertained and documented in a clinical way. Then, even as the person begins to self administer, staff may continue to chart the person's intake, so as to ensure that the skill is maintained.

- Even in Supported Independent Living, where most people do self administer, it is important for staff to monitor new medications and changed dosages to ensure correct usage.

- In every case, support staff must record all prescribed medication on the person's AIMS *Medication Tab.*

- People in Supported Independent Living have independent access to non-prescription medications, and these will only be formally monitored at the discretion of the person and support staff.

- The degree of support required by each person, and the strategy for delivering that support (e.g. phone calls, calendars, etc.) must be documented in his or her *Support Information* document (form B-10).

- In the case of a group living program that has Supported Independent Living status primarily for administrative or financial reasons (e.g. the need of the residents to apply directly for a housing subsidy), it may be determined that Procedure B-11-3 *Administering Medications* will apply throughout the home, as in most group homes, or that it apply to specific people. Information to this effect will be recorded in each person's *Support Information* document.

Procedure No: B-11-14	Effective Date: April 1, 2010
Administering Medications in Day Programs	Last Revision: September 26, 2012
	Last Review: November 9, 2021

- Like staff based in residential programs, staff in the Community Support Programs have an obligation to ensure the health and safety of people receiving service. However, they typically do not liaise directly with physicians or have ready access to the same level of detail concerning each person's health.

- When people receiving a residential service access a Community Support Programs and are not accompanied by staff, then, should they require medication, residential staff will complete an *Authorization to Dispense Medication,* form B-5, and deliver it to the Community Support staff designated to receive it. This form will constitute a standing order until such time as the medication is discontinued or changed.

- The Authorization must include the following information:
    a. Name of Drug
    b. Dosage
    c. Time to be administered
    d. Specific Route Instructions, e.g. with water, right ear, with food, etc.

- Community Support staff will place the written request in the Medication Binder and transcribe all pertinent information onto the *Medication Administration Record* (form C-6).

- The Community Support staff administering the medication will do so in accordance with Procedure B-11-3 *Administering Medications*.

- If someone residing in a group home or in a Family Home situation is learning, or has learned, to self-medicate, the special protocol for him or her will be detailed in his/her *Support Information* document (form B-10) to which Community Support staff have access.

- In the case of individuals who reside with their families, written authorization will typically be expected, and in the absence of such authorization, parents or guardians will

be contacted by telephone. However, if a person who lives with family, and who is largely independent in many aspects of his or her life, is found self-medicating, staff will have to make a judgment as to whether a call home would be unnecessarily intrusive.

Approved by: Glenn Taylor
CEO

Date: February 9, 2024