Understanding California Medication Regulations

Learner Workbook

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UNDERSTANDING CAL MEDICATION REGULATIONS

In this course we will address key concepts from California RCFE Medication regulations, including handling of physician orders, PRN medications, eye drops, and more. Always be sure to talk with your supervisor if you have any questions regarding any medication regulations.

Important Notice

This section is intended to familiarize all staff with basic medication regulations in California. Completing this section does not qualify the person to provide assistance with self-administration or to otherwise handle medications.

The following is adapted from the California Department of Social Services, Community Care Licensing Medication Self-Assessment Guide.

What You Should Do When …

A Resident Arrives with Medication:

When a resident arrives with medication, you should contact the physician(s) to ensure that he/she is aware of all medications currently being taken by the resident. Verify medications that are currently taken by the resident and the dispensing instructions.

You should inspect containers to ensure the labeling is accurate. Be sure to log all medications accurately on forms for resident records. The Centrally Stored Medication and Destruction Record (LIC 622) is available for this purpose.

Discuss medications with the resident or the responsible person/authorized representative. Be sure to store medications in a locked compartment.

Medication Is Refilled:

It is essential to communicate with the physician or others involved (for example, discuss procedures for payment of medications, who will order the medications, etc. with the responsible person.)

Never let medications run out unless directed to by the physician. Make sure refills are ordered promptly to avoid running out.

Inspect containers to ensure all information on the label is correct. Note any changes in instructions and/or medication (for example, change in dosage, change to generic brand, etc.)

Be sure to log the medication when received on the LIC 622 form.

Discuss any changes in medications with the resident, responsible person/authorized representative, and appropriate staff.

A Dosage Is Changed Between Refills:

Confirm with the physician when a dosage has been changed between refills. Obtain written documentation of the change from the physician or document the date, time, and person talked to in resident's record.

Prescription labels cannot be altered by community staff. Have a community procedure (i.e., card file/cardex, notebook, and/or a flagging system) to alert staff to the change.

Discuss the change with resident and/or responsible person/authorized representative.

Medication Is Permanently Discontinued:

When medication has been permanently discontinued, be sure to confirm with the physician. Obtain written documentation of the discontinuation from the physician or document the date, time, and person talked to in resident's record.

Discuss the discontinuation with the resident and/or responsible person/authorized representative.

Have a facility procedure (i.e., card file/cardex, notebook, and/or a flagging system) to alert staff to the discontinuation.

Destroy the medication. Medication must be destroyed by the facility administrator or designee and one other adult who is not a resident.

Sign the medication destruction record/log. The reverse side of LIC 622, Centrally Stored Medication Record, may be used for this purpose.

Medications Are Temporarily Discontinued ("dc") and/or Placed On Hold:

Medications temporarily discontinued by the physician may be held on the facility. Discuss the change with the resident and/or responsible person/authorized representative.

Obtain a written order from the physician to HOLD the medication, or document in the resident's file the date, time, and name of person talked to regarding the HOLD order.

Have a facility procedure (i.e., card file/cardex, notebook, and/or a flagging system) to alert staff to the discontinuation and restart date.

Without altering the label, mark or identify in a consistent manner medication containers that have HOLD orders.

Be sure to contact the physician after the discontinuation/hold order expires to receive new instructions regarding the use of the medication.

Medication Reaches Expiration Date:

Be sure to check containers regularly for expiration dates. Communicate with physician and pharmacy promptly if a medication expires.

Do not use expired medications. Obtain a refill as soon as possible if needed.

Over-the-counter medications and ointments also have expiration dates (for ointments the expiration date is usually at the bottom of the tube).

Destroy expired medications according to regulations. Log/record the destruction of prescription medications as required. The LIC 622 may be used for this purpose.

Resident Transfers, Dies, Or Leaves Medication Behind:

All medications, including over-the-counters, should go with resident when possible. If the resident dies, prescription medications must be destroyed.

Be sure to log/record the destruction as required. The LIC 622 may be used for this purpose. Document when medication is transferred with the resident. Obtain the signature of the person accepting the medications (i.e., responsible person/authorized representative.)

Maintain medication records for at least (3) three years (RCFE).

Resident Missed or Refused Medications:

No resident can be forced to take any medications. Missed/refused medications must be documented in the resident's medication record and the prescribing physician contacted immediately.

Notify the responsible persons/authorized representative.

Refusal of medications may indicate changes in the resident that require a reassessment of his/her needs. Continued refusal of medications may require the resident's relocation from the facility.

Medications Need To Be Crushed or Altered:

Medications may be crushed or altered to enhance swallowing or taste, but never to disguise or "slip" them to a resident without his or her knowledge.

The following written documentation must be in the resident's file if the medication is to be crushed or altered:

- A physician's order specifying the name and dosage of the medication to be crushed;

- Verification of consultation with a pharmacist or physician that the medication can be safely crushed, identification of foods and liquids that can be mixed with the medications, and instructions for crushing or mixing medications;

- A form consenting to crushing the medications signed by the resident. If the resident has a conservator with authority over his/her medical decision, the consent form must be signed by that conservator.

Medications Are PRN or "As Needed":

Community staff may assist the resident with self-administration of his/her prescription and nonprescription PRN medication when:

- The resident's physician has stated in writing that the resident can determine and clearly communicate his/her need for a prescription or nonprescription PRN medication.

- The physician provides a signed, dated, written order for the medication on a prescription blank or the physician's business stationery which is maintained in the resident's file.

- The physician's order and the PRN medication label identify the specific symptoms that indicate the need for use of the medication, exact dosage, minimum hours between doses, and maximum doses to be given in a 24-hour period. Most nonprescription labels display this information.

Community staff may also assist the resident with self-administration of his/her nonprescription PRN medication if the resident cannot determine his/her need for a nonprescription PRN medication, but can communicate his/her symptoms clearly, when:

- The resident's physician has stated in writing that the resident cannot determine his/her need for nonprescription medication, but can communicate his/her symptoms clearly.

- The resident's physician provides a signed, dated, written order on a prescription blank or the physician's business stationary which is maintained in the resident's file.

- The written order identifies the name of the resident, the name of the PRN medication, instructions regarding when the medication should be stopped, and an indication when the physician should be contacted for reevaluation.

- The physician's order and the PRN medication label identify the specific symptoms that indicate the need for use of the medication, exact dosage, minimum hours between doses, and maximum doses to be given in a 24-hour period. Most nonprescription medication labels display this information.

- A record of each dose is maintained in the resident's record and includes the date, time, and dosage taken and the resident's response.

Community staff may also assist the resident with self-administration of his/her prescription or nonprescription PRN medication if the resident cannot determine his/her need for a prescription or nonprescription or nonprescription PRN medication and cannot communicate his/her symptoms when:

- Community staff contacts the resident's physician before giving each dose, describe the resident's symptoms, and receive permission to give the resident each dose.

- The date and time of each contact with the physician and the physician's direction are documented and maintained in the resident's facility record.

- The physician provides a signed, dated, written order on a prescription blank or the physician's business stationery which is maintained in the resident's file.

- The physician's order and the PRN medication label identify the specific symptoms that indicated the need for use of the medication, exact dosage, minimum hours between doses, and maximum doses to be given in a 24-hour period.

- A record of each dose is maintained in the resident's records and includes the date, time, each dosage taken and the resident's response.

Medications Are Injectables:

Injections can only be administered by the resident or by a licensed medical professional. Licensed medical professional includes Doctors of Medicine (M.D.), Registered Nurses (R.N.), and Licensed Vocational Nurses (L.V.N.) or a Psychiatric Technician (P.T.). P.T.'s can only administer subcutaneous and intramuscular injections to residents with developmental or mental disabilities or mental disabilities and in accordance with a physician's order.

Family members are not allowed to draw up or administer injections in an RCFE unless they are licensed medical professionals.

Community personnel who are not licensed medical professionals cannot draw up or administer injections in RCFEs.

Licensed medical professionals may not administer medications/insulin injections that have been pre-drawn by another licensed medical professional.

Injections administered by a licensed medical professional must be provided in accordance with the physician's orders.

The physician's medical assessment must contain documentation of the need for injected medication.

If the resident does administer his/her own injections, physician verification of the resident's ability to do so must be in the file.

Sufficient amounts of medications, test equipment, syringes, needles, and other supplies must be maintained in the community and stored properly.

Syringes and needles should be disposed of in a "container for sharps," and the container must be kept inaccessible to residents (locked).

Only the resident or the licensed medical professional can mix medications to be injected of fill the syringe with the prescribed dose.

Insulin and other injectable medications must be kept in the original containers until the prescribed single dose is measured into a syringe for immediate injection.

Insulin or other injectable medication may be packaged in pre-measured doses in individual syringes prepared by a pharmacist or the manufacturer.

Syringes may be pre-filled under the following circumstances:

- Residential Care Facilities for the Elderly, Group Homes and Small Family Homes must obtain exceptions form the licensing office for residents to use pre-filled syringes prepared by a registered nurse.

- The registered nurse (R.N.) must not set up insulin syringes for more than seven days in advance.

Injectable medications that require refrigeration must be kept locked.

Over-The-Counter (OTC) Medications, Including Herbal Remedies, Are Present:

OTC medications (e.g., aspirin, cold medications, etc.) can be dangerous. They must be centrally stored to the same extent that prescription medications are centrally stored. Over-the-counter medication(s) that are given on a PRN basis must meet all PRN requirements. (Review above section “Medications are PRN or ‘As Needed”)

Physicians must approve the use of all OTC medications that are or may be taken by the resident on a regular basis (e.g., aspirin for heart condition, vitamins, etc.) as well as those used on a PRN basis. Have documentation.

Resident’s name should be on the over-the-counter medication container when:

- It is purchased for that individual’s sole use;

- It is purchased by resident’s family, or

- The resident’s personal funds were used to purchase the medication.

You “Set Up” or “Pour” Medications:

Have clean, sanitary conditions. (i.e., containers, counting trays, pill cutters, pill crushers and storage/setup areas.)

Pour medications from the bottle to the individual resident’s cup/utensil to avoid touching or contaminating medication.

Medication must be stored in the original containers and not transferred between containers.

Be sure to have written procedures for situations such as spillage, contamination, assisting with liquid medication, interactions of medications, etc. Also, you should have written procedures for community staff regarding assisting with administration of medication, required documentation, and destruction procedures.

Assisting With Medication (Passing):

Staff passing medications need to ensure that the resident actually swallows the medication (not “cheeking” the medication); mouth checks are an option for staff.

Cups or envelopes containing medications should not be left unattended in the dining room, bathrooms, bedrooms, or anywhere in the facility.

Medications are received or destroyed:

Every prescription medication that is centrally stored or destroyed in the facility must be logged.

A record of prescription medications that are disposed of in the facility must be maintained for at least 3 years.

Medications are prepackaged:

Prepackaged medications (bubble packs, trays, cassettes, etc.) are allowed if they are packed and labeled by a pharmacy.

Licensees and/or facility staff cannot remove discontinued medications from customized medication packages.

Multi-dose packages must be returned to the pharmacy for changes in doses or discontinuation of a medication.

Facilities should have procedures in case one dose is contaminated and must be destroyed.

Sample Medications Are Used:

Sample medications may be used if given by the prescribing physician.

Sample medications must have all the information required on a regular prescription label except pharmacy name and prescription number.

Transferring Medications For Home Visits, Outings, Etc.

When a resident leaves the facility for a short period of time during which only one dose of medication is needed, the facility may give the medications to a responsible person/authorized representative in an envelope (or similar container) labeled with the facility's name and address, resident's name, name of medication(s), and instructions for administering the dose.

If resident is to be gone for more than one dosage period, the facility may:

- Give the full prescription container to the resident, or responsible person/authorized representative, or

- Have the pharmacy either fill a separate prescription or separate the existing prescription into two bottles, or

- Have the resident's family obtain a separate supply of the medication for use when the resident visits the family.

If it is not safe to give the medications to the resident, the medications must be entrusted to the person who is escorting the resident off the facility premises.

If medications are being sent with the resident off the facility premises, check the Physician's Report (LIC 602 or 602a) to ensure that they are given only to residents whose doctors have indicated that they may control their own medications.

Always have the person entrusted with the medications sign a receipt which identifies the number and type of medications sent out and returned.

House Medications/Stock Supplies Of Over-The-Counter Medications Are Used:

Centrally stored, stock supplies of over-the-counter medications may be used.

Licensees cannot require residents to use or purchase house supply medications.

Residents may use personal funds to purchase individual doses of OTC medications from the licensee's stock if each dose is sold at the licensee's cost and accurate written records are maintained of each transaction.

All regulations regarding the use of OTC medications must be followed (see section #12).

Be sure to verify that the resident's physician has approved the use of the OTC before giving him/her a dose from the house supply.

Residents Use Emergency Medication(S) (E.G., Nitroglycerin, Inhaler, Etc.):

Residents who have a medical condition requiring the immediate availability of emergency medication may maintain the medication in their possession if all of the following conditions are met:

- The physician has ordered the PRN medication, and has determined and documented in writing that the resident is capable of determining his/her need for a dosage of the medication and that possession of the medication by the resident is safe.

- This determination by the physician is maintained in the individual's file and available for inspection by Licensing.

- The physician's determination clearly indicates the dosage and quantity of medication that should be maintained by the resident.

- Neither the facility administrator nor the Department has determined that the medications must be centrally stored in the facility due to risks to others or other specified reasons.

- If the physician has determined it is necessary for a resident to have medication immediately available in an emergency but has also determined that possession of the medication by the resident is dangerous, then that resident may be inappropriately placed and may require a higher level of care.

Blood Pressure And Pulse Readings Are Taken:

The following persons are allowed to take blood pressure and pulse readings to determine the need for medications:

- The resident when his/her physician has stated in writing that the resident is physically and mentally capable of performing the procedure.

- A physician or registered nurse.

- A licensed vocational nurse under the direction of a registered nurse or physician.

- A psychiatric technician under the direction of a physician, surgeon, psychiatrist, or registered nurse. Psych technicians may take blood pressure and pulse readings of residents in any community care licensed facility. The psychiatric technician injection restrictions noted in section #11 do not apply to taking vital signs.

The licensee must ensure that the following items are documented when the resident's vital signs are taken to determine the need for administration of medications:

- The name of the skilled professional who takes the reading.

- The date and time and name of the person who gave the medication.

- The resident's response to the medication.

Lay staff may perform vital sign readings as long as the readings are not used to determine a need for medication.

Residents Need Assistance With The Administration Of Ear, Nose And Eye Drops:

The resident must be unable to self-administer his/her own eye, ear, or nose drops due to tremors, failing eyesight, or other similar conditions.

The resident's condition must be chronic and resistant to sudden change (stable), or temporary in nature and expected to return to a condition normal for the resident.

The resident's Pre-Admission Appraisal (RCFE) or Individual Services Plan must state that he/she cannot self-administer his/her own drops and specify how staff will handle the situation.

The resident's physician must document in writing the reasons that the resident cannot self-administer the drops, the stability of the medical condition and must provide authorization for the staff to be trained to assist the resident.
Staff providing the resident with assistance must be trained by a licensed professional, and names of trained staff must be maintained in the staff files.

- This training must be completed prior to providing the service,

- Must include hands-on instruction in general and resident specific procedures, and

- Must be reviewed and updated by the licensed professional at least annually or more often if the condition changes.

Staff must be trained by a licensed professional to recognize objective symptoms observable by a lay person and to respond to the resident's health problem.

Staff must be trained in and follow universal precautions and any other procedures recommended by the licensed professional.

Written documentation outlining the procedures to be used in assisting the resident with the drops and all aspects of care to be performed by the licensed professional and facility staff must be maintained in the resident's file.

Prior to providing ongoing resident assistance with drops, facility staff should consider the use of assistive devices, such as an eye cup, which would enable the resident to self-administer the drops.

Medications Need To Be Stored:

All medications, including over-the-counters, must be locked at all times.

All medications must be stored in accordance with label instructions (e.g., refrigerate, room temperature, out of direct sunlight, etc.).

Medication in refrigerators needs to be locked in a receptacle, drawer, or container separate from food items. Caution should be used in selecting storage containers as metal may rust.

If one resident is allowed to keep his/her own medications, the medications need to be locked to prevent access by other residents.

Miscellaneous:

Medications are one of the most potentially dangerous aspects of providing care and supervision.

Educate yourself and staff (signs, symptoms, side effects).

Train staff.

Develop a plan to evaluate staff's ability to comply with the facility's medication procedures.

Communicate with physicians, pharmacists, and appropriately skilled professionals.

Develop a system to communicate changes in resident medications to staff and to the resident.

Staff should be trained on universal precautions to prevent contamination and the spread of disease.

Document.

Know your residents.

Be careful.