

LHC GROUP, INC.	MEDICATION ADMINISTRATION
EFFECTIVE DATE: 11/01/2015	DIVISION: HOME AND COMMUNITY BASED SERVICES
REVISED DATE: 07/1/2020, 10/01/22	CHAPTER: MEDICATION MANAGEMENT
APPROVED BY: POLICY COMMITTEE	POLICY NUMBER: 3.002
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PURPOSE:

To provide a process to ensure safe administration of medications in the home

POLICY:

It is the responsibility of the licensed clinician to determine if medication administration is a function allowable per his/her state practice act.

The Executive Director, with attending physician, will make the decision regarding medication administration in the home. Licensed Practical Nurses may only administer intravenous (IV) medications if allowable by state law or state Nurse Practice Act and once specific competency is established and documented.

Agency professional staff may administer, if allowable by state law:

- Coagulants and anticoagulants by subcutaneous (SQ), intramuscular (IM), or IV routes
- Antibiotics, antifungals, antivirals by topical, IM, or IV routes
- Antineoplastic drugs that do not require direct physician supervision or those that do not have a high incidence of ventricular reservoir or anaphylaxis by SQ, IM, or IV routes
- Gold compounds by IM routes
- Narcotics or pain medications by SQ, IM, IV (including Patient Controlled Analgesia (PCA) Pump), or Intraspinal routes
- First dose of SQ, IM, or IV medication if criteria met. (Refer to First Dose Therapy in the Home Setting Policy)
- Medications by ophthalmic, otic, oral, nasal, or topical route
- Diuretics

Agency professional staff may not administer:

- Drugs that require direct physician supervision.
- Drugs that have high incidence of anaphylaxis. (i.e., L-asparaginase).
- Experimental drugs without informed written consent of patient. (Refer to Research, Investigations and Clinical Trials Policy)
- Experimental drugs initiated at home.

PROCEDURE:

1. The physician's order will contain:
 - a. Name of medication, dose, dilution, frequency, route, rate of infusion, duration of therapy, and indications for prn medications,
 - b. Dosage expressed in metric system except when it must be expressed otherwise as in units,
 - c. Lab work, as appropriate

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- d. Specific anaphylaxis treatment, if indicated,
- e. Date order was written and by whom it was written; and
- f. Signature and date of physician.

For titration orders (orders in which the dose is either progressively increased or decreased in response to the patient's status), the order must include initial rate of infusion, incremental units to which the rate or dose can be increased or decreased, how often the rate or dose can be changed, the maximum rate or dose of infusion, and the objective clinical measures to guide change

2. The clinician will check all medications the patient is taking to identify possible ineffective drug therapy or adverse reactions, significant side effects, drug allergies, contraindicated medication(s), and known drug to drug interactions and shall report any problems to the physician. The clinician will educate the patient on signs and symptoms to report and will continue to assess the patient at every visit to ensure there are no adverse events.
3. The RN will initiate a medication profile upon admission and will update with any changes throughout the course of care. The medication profile will include:
 - a. Name, classification, dose, strength, frequency, and route of medication
 - b. Duration of therapy (i.e., antibiotics end date)
 - c. Date ordered (if known)
 - d. All over the counter medications
 - e. Contraindications and/or precautions
 - f. IV medication flush concentrations and amount
 - g. Amounts and flushes for g tube, peg tube, and Mickey buttons
 - h. Any known allergies
4. For patients at risk for medication misuse or abuse or with medications considered controlled substances, nurses in the home will:
 - a. Assess and determine the need to limit medication, by maintaining controlled substances in a medication locked box, with written consent received from the patient/patient's caregiver. Use of a medication lock box will be included in the patient's plan of care.
 - b. Count narcotics with the oncoming nurse at shift change and document findings, including staff initial and date and time of count. In the event where a nurse is not present in the home continuously, the count will be performed with the patient or family member/caregiver.

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- c. Any concerns related to suspected abuse of medications will be reported immediately to the Executive Director for follow up and investigation, and an incident report completed.

5. The nurse will observe the “five rights” when administering or preparing medications.
 - (1) right drug
 - (2) right dose
 - (3) right patient
 - (4) right time
 - (5) right route

6. The label on the medication container must be read at three intervals.
 - (1) when it is taken from the storage area
 - (2) when dispensing the medication
 - (3) before returning it to the storage area

7. Individual prefilled syringes (i.e., insulin, Calcimar or vaccines) that are prepared by the nurse/physician office staff, to be administered by the patient/family/caregiver or staff, should be labeled with the following information:
 - a. Patient name
 - b. Medication name, strength, and amount (if not apparent from container)
 - c. Expiration date when not used within 24 hours and expiration time when expiration occurs within 24 hours
 - d. Date syringes prepared
 - e. Diluents for all compound intravenous admixtures and parenteral nutrition formulas, as applicable
 - f. Any cautionary information, i.e., “Keep refrigerated,” “Remove from refrigerator 15 minutes prior to administration”
 - g. Name/signature of the nurse preparing the syringes

It is acceptable to store multiple prefilled syringes that are identical in contents (such as insulin) in a container or plastic bag and include the above required labeling components on the container bag.

8. When preparing medication, the nurse will not administer the following:
 - a. Medications from containers or vials that are unmarked.
 - b. Medications that are cloudy or have changed color (The nurse will verify if medication is normally cloudy)
 - c. Medications that have precipitated, unless the medication is one that requires shaking before use

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- d. Medications that exceed expiration date
9. Patients have the right to know the name and the action of the drug they are taking, unless contraindicated by their physician. Patients have the right to refuse medication.
10. Medications are withheld:
 - a. If contraindications exist, such as known allergies to the medication
 - b. If there are incompatibilities with other medications being given to the patient
 - c. If laboratory results indicate the medication should be withheld, per physician parameters
 - d. Due to information obtained in discussions with the patient and/or physician, and
 - e. If the patient refuses the medication.
(In these cases, the clinician contacts the physician for appropriate orders.)
 11. When preparing medication from a multi-vial to single patient use, the clinician shall label according to the above specified method.

Self-Administered Medications:

1. The clinician assesses and determines the patient's/family's/caregiver's ability to learn the medication regimen safely and accurately, based on the patient's needs and patient's/family's/caregiver's cognitive and learning abilities, taking into consideration cultural and ethnic factors. This determination is documented in the medical record throughout the episode of care.
2. The patient's/family's/caregiver's current level of knowledge about the medication's regimen is assessed and documented in the medical record.
3. The clinician will instruct the patient/family/caregiver in an understandable format and language regarding the following:
 - a. name(s) and classifications of medications ordered (i.e., the reason why the medications have been ordered)
 - b. manner in which to administer the medications, including appropriate frequency, dosage, and route of administration
 - c. expected actions and side effects of the medications to be administered
 - d. Special instructions about the medication administration (i.e., to take with/without food, to remain sitting for 30 minutes after ingestion of the medication, to crush or not crush tablets, and to monitor the patient's pulse before administration)
 - e. How to determine whether the medication is having the desired effect
 - f. Potential side effects of the medications that may occur

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4. The clinician evaluates the patient's/family's/caregiver's competency in adhering to the medication regimen and the instructions provided. The evaluation may include, but is not limited to, the following:
 - a. Counting the number of remaining units of medication to determine whether the correct frequency and dosage has been followed
 - b. Having the patient/family/caregiver repeat the instructions during a subsequent visit
 - c. Having the patient/family/caregiver demonstrate adherence to the instructions provided at a subsequent visit
5. The clinician should document the specific instructions provided, taking into consideration adult learning principles, the patient's/family's/caregiver's needs, cognitive abilities, and cultural and ethnic issues. The clinician shall document all instructions in the medical record.
6. Documentation of the patient's/family's/caregiver's response to the medication regimen instructions should be specific as to their competency and ability to adhere to the medication regimen.
7. The ordering physician involved in the patient's medication management is informed of the patient's/family's/caregiver's progress toward outcomes.