

Medication Administration Program Certification Training

“Administering Medication the Right Way”



Mass.Gov





Successful Completion

❖ **100% Attendance**

❖ **Pre-Test(s)**

- **Computer Based Pretest**
- **Medication Administration**
- **Transcription**



Computer Based Pretest

- ❖ **30 Multiple choice questions**
 - **General knowledge**
 - **Document based questions (DBQs)**
- ❖ **35 Minute time limit**
- ❖ **80% Or better is passing**



D&S Diversified Technologies LLP
D&S Diversified Technologies LLP

Massachusetts MAP Testing and Registry

Innovative, quality technology solutions
throughout the United States
since 1985.



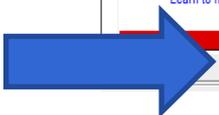
NEW KNOWLEDGE AND SKILLS TEST LOCATION

HORACE MANN EDUCATIONAL ASSOC, FRANKLIN, MA

They will offer open testing on knowledge once a month and open testing on skills once a month starting in October.

Thank you to all of our test sites for providing such a valuable service to the MAP community!!!

Candidate Forms	Test Site Forms & MAP Trainers	Knowledge Test Proctor & RN Observer Forms	Contacts
Testing Application Form 1101	Test Site Agreement Form 1502	MAP RN Observer Application Form 1500	Please feel free to contact us if you have questions, concerns, or suggestions about our service. We value the feedback we receive from everyone involved in the Massachusetts MAP testing and certification process. D&S Diversified Kelly Buerger Program Manager 333 Oakland Findlay, OH 45840 Phone: (877) 851-2355 Fax: (419) 422-7395 hdmastereast@hdmaster.com
Three Month Test Schedule	Test Site Equipment List Form 1503	Confidentiality/Nondisclosure Agreement Form 1501	
Rate Structure Form 1402	Medication Administration MOCK Testing Instructions	Knowledge Test Proctor Agreement Form 1515	
MAP Candidate Handbook 3.1f Effective August 19, 2014	Transcription MOCK Testing Instructions	MAP RN Observer Equipment List	
Frequently Asked Questions	Sample Transcription Medication Sheet	Test Observer Agreement Form 1505	
ADA Accommodation Form 1404	Sample Transcription Documents	Knowledge Test Proctor Certification Form 1511	
Online Enrollment Form 1600	WebTest © On-line Testing	Medication Administration Test Instructions	
Sign Language Interpreter Scheduled Dates	WebTest © Start Page	Transcription Test Instructions	
Demonstration Med Pass Video	Select the above link to... <ul style="list-style-type: none"> • register candidates for the exam • cancel or reschedule an exam • complete the exam as a candidate • submit an exam package for scoring 	Medication Administration PRETEST	
Warm-up Test Short Cut	Easy Steps for the Training Program Interface	Instructions and Pretest Documents	
Learn to navigate an on-line test (opens in new window)	Training Program Reports	PIIN Request Forms	
Computer Based Pretest		MAP Trainer Pin Request Form	
Pretest		Provider Pin Request Form	
		Weekly Updates from Sharon	
			Visitors <div style="border: 1px solid black; padding: 5px; display: inline-block;">547 550</div>





Important Instructions:

- The pretest requires the use of **supporting documents** that will be supplied by your trainer at the completion of your course or ...
- You also have a link to **supporting documents** at the bottom of the question page.
- For score verification, your trainer will require that you provide a printed copy of the score report provided when you complete the pretest.
- You have 35 minutes to complete the pretest.
- Successful completion of the pretest does not provide for MAP certification, but is one step that is required to register for the MAP Certification Exam.
- Your **identification number** is your social security number or test ID and your results cannot be submitted to your trainer if you do not enter your ID.
- Your **identification number** is securely encrypted, and will not appear on any printed documents.



Please enter your identification number

[Click here to start a PRETEST](#)

NOTE: You must enable **COOKIES** on your browser to take the warmup exam.

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Computer Based Pretest

Massachusetts MAP KNOWLEDGE PRETEST

CANDIDATE, SAMPLE Time Remaining: 00:34:37 (hh:mm:ss)

[Previous Question](#) [Next Question](#) [Jump To Question...](#) ? [Stop Exam](#) [Help](#)

#4. The telephone number of Acme Pharmacy is (800) [refer to documents]

a. 626-0803
 b. 540-1111
 c. 729-2222
 d. 456-1632

Check for future review Items Bookmarked:
Questions Remaining: 1-30.
[Click here to view required documents.](#)



Gina Hunt, RN

- ❖ **gina.hunt@state.ma.us**
- ❖ **508-572-3489 text**
- ❖ **978-739-0425 fax**
- ❖ **978-774-5000 x354**



Med Pass Pretest

- ❖ **Medication Administration**
 - **Each staff will be observed (at least once) apply your knowledge of the 3 checks of the 5 rights**
 - **Feedback by Trainer/Peer**
 - **80% Accuracy**



ID Clarification

The International Driver's Document (Translation of Foreign Driver's License) is not a US Government issued ID and will not be accepted as the government issued ID at any MAP test.

Wrist Watch Cell Phones

Due to recent advancements in technology, there are now fully functional wrist watch cell phones with full internet access. Due to this advancement and the large number of styles available staff will no longer be able to wear watches for the knowledge or transcription tests. Staff will be closely monitored during the medication administration test since that test is administered one on one. This policy is in effect immediately.

Candidate Forms	Test Site Forms & MAP Trainers	Knowledge Test Proctor & RN Observer Forms	Contacts
Testing Application Form 1101 Three Month Test Schedule Rate Structure Form 1402 MAP Candidate Handbook 3.1f Effective August 19, 2014 Frequently Asked Questions ADA Accommodation Form 1404 Online Enrollment Form 1600 Sign Language Interpreter Scheduled Dates	Test Site Agreement Form 1502 Test Site Equipment List Form 1503 Medication Administration MOCK Testing Instructions Transcription MOCK Testing Instructions Sample Transcription Medication Sheet Sample Transcription Documents WebETest © On-line Testing WebETest © Start Page Select the above link to... <ul style="list-style-type: none"> • register candidates for the exam • cancel or reschedule an exam • complete the exam as a candidate • submit an exam package for scoring 	MAP RN Observer Application Form 1500 Confidentiality/Nondisclosure Agreement Form 1501 Knowledge Test Proctor Agreement Form 1515 MAP RN Observer Equipment List Test Observer Agreement Form 1505 Knowledge Test Proctor Certification Form 1511 Medication Administration Test Instructions Transcription Test Instructions Medication Administration PRETEST Instructions and Pretest Documents PIN Request Forms MAP Trainer Pin Request Form	Please feel free to contact us if you have questions, concerns, or suggestions about our service. We value the feedback we receive from everyone involved in the Massachusetts MAP testing and certification process. D&S Diversified Kelly Buerger Program Manager 333 Oakland Findlay, OH 45840 Phone: (877) 851-2355 Fax: (419) 422-7395 hdmastereast@hdmaster.com Visitors 563932





Transcription Pretest

❖ Transcription

- DC one med
- Transcribe one med
 - 15 Minutes
 - 100% Accuracy



D&S Diversified Technologies

Three Components

1. Computer based test-75 min.

50 questions (40/50 is passing)

Skills

2. Transcription-15 min.

3. Med administration-10 min.

Apply knowledge of 5 Rights while verbally demonstrating 3 Checks



Medication Certification

- ❖ **Meds may be administered in**
 - **DDS adult**
 - **DMH/DCF adult and youth**
- funded, operated or licensed programs**

- ❖ **Good for 2 years**



Certification Letter

Massachusetts MAP Certification	
Name	Allen G Richards
Cert. Date	01/27/2014
Exp. Date	01/31/2016
Test ID	0504244400



Fictional Characters

❖ **Melissa**

❖ **Chip**

❖ **Freddy**



Community Resources





MAP Consultant

- ❖ **Registered Nurse**
- ❖ **Pharmacist**
- ❖ **Authorized Prescriber**
 - **Health Care Provider (HCP)**
 - **Nurse Practitioner**
 - **Dentist, etc.**



Learning Strategies

- ❖ **Objectives**
- ❖ **Terms to Study**
- ❖ **Apply What You've Learned**
- ❖ **Exercises**



Required for Medication Administration

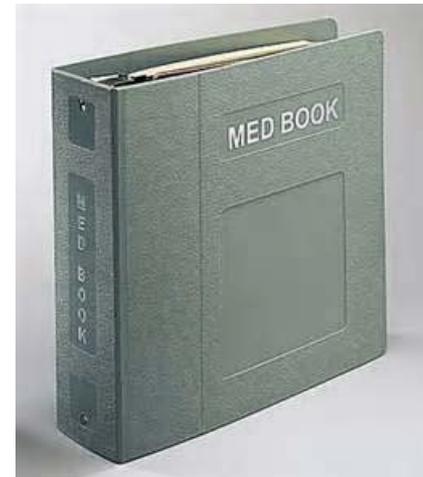
- ❖ **HCP order**
- ❖ **Pharmacy label**
- ❖ **Medication (med) sheet**



Medication Book

❖ Contents

- **HCP orders**
 - HCP visit encounter form (if it includes an order)
- **Med sheets**
 - Acceptable codes
 - Med progress notes
- **Medication information sheets**

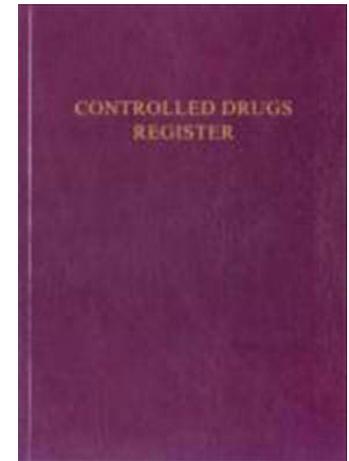




Countable Substances Book

Three sections

1. Index
2. Count sheets
3. Shift count sheets





Medication Administration Basics



Safe Medication Administration

❖ Standardization





Knowing the People You Support

❖ Helps

- To recognize changes
- When reporting
- When documenting



Respecting Rights

- ❖ **Everyone has the right to**
 - **Be treated with respect and dignity**
 - **Be free from too much medication**
 - **Know what meds they are taking**
 - **Know about risks and benefits**
 - **Refuse medication**



Principles

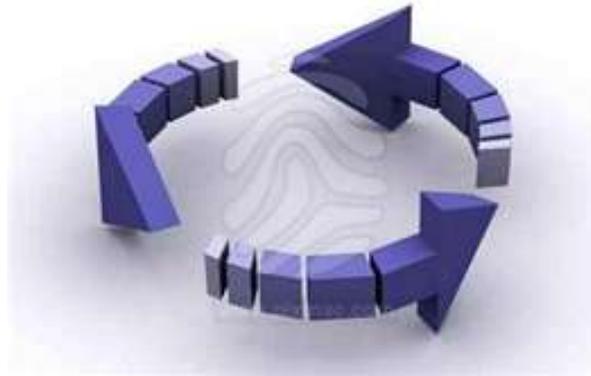
- **Mindfulness**
- **Maximizing Capabilities**
- **Communication**





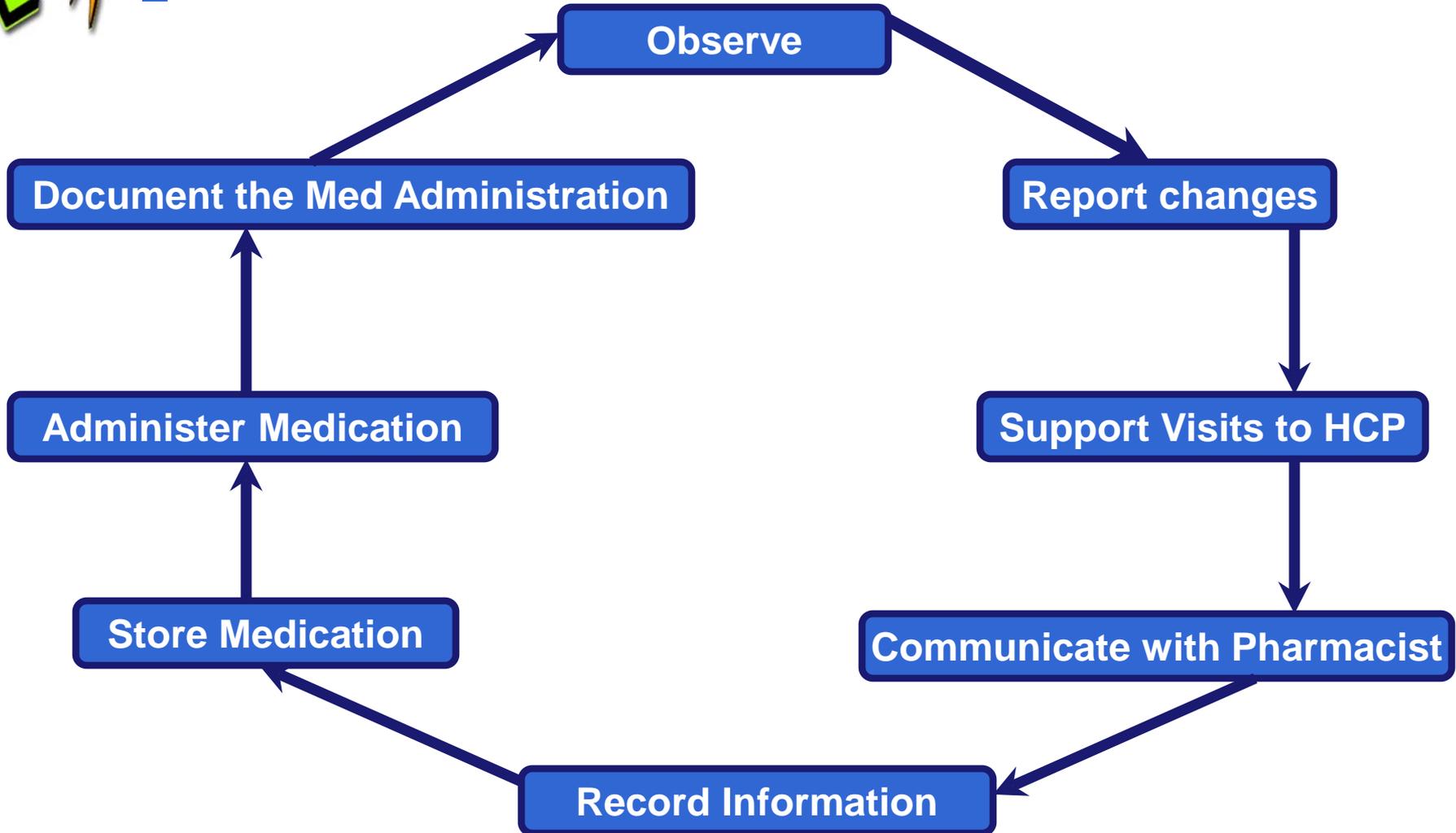
Safe Medication Administration

❖ Cycle of Responsibility





Cycle of Responsibility





Daily Routine

- ❖ **Come to work ready to**
 - **Talk with other staff**
 - **Greet person**
 - **Ask how person is doing**
 - **Pay attention to behavior**



How to Prevent and Control Infection



Prevent and Control Infection

❖ Hand washing

- When
- How





Prevent and Control Infection

❖ Glove use

- When
- How





- ❖ **The Cycle of Responsibility**
 - **General Guidelines**
 - **Medication Administration**



The Five Rights

- **Right Person**
- **Right Medication**
- **Right Dose**
- **Right Time**
- **Right Route**



Right Person

If uncertain get help

- **Ask other staff**
- **Check picture**



Right Medication

- **If HCP writes brand name on prescription**
 - **Pharmacist will usually substitute with generic**
- **If unsure**
 - **Ask pharmacist**





Right Medication

- **If familiar with med but notice change in**
 - **Color**
 - **Size**
 - **Shape**
 - **Markings, etc.**
- **Ask the Pharmacist**



Right Dose

- **HCP orders dose**
 - **Usually written in “mg”**
 - **Milligrams**



Right Time

- **Particular time of day**
- **Number of times per day**
- **Time between doses**



Right Time

- **Most meds can be given safely**
 - **One hour before &**
 - **Up to one hour after time on med sheet**
- **If unsure**
 - **Ask pharmacist**



Right Route

- ❖ **Form of med determines the route**
 - **Tabs, caps, liquids (usually oral)**
 - **Ointment to skin (topical)**





General Guidelines

- ❖ **Three cross checks of the Five Rights **before** administration**



How to Administer Medication



Medication Administration

❖ Process

- Prepare
- Administer
- Complete



Prepare

- ❖ **Figure out the meds to give**
 - Know the reason ordered
- ❖ **Clean area**
- ❖ **Wash hands**
- ❖ **Gather supplies needed**
- ❖ **Identify individual**
- ❖ **Unlock storage area**
- ❖ **Open count book**
 - If needed



Administer

- ❖ **Cross check one**
- ❖ **Cross check two**
 - **Prepare med**
- ❖ **Cross check three**
 - **Give med**
- ❖ **Look again**



Complete

- ❖ **Document**
- ❖ **Lock**
- ❖ **Wash hands**
- ❖ **Observe for effects**



Medication Administration

MEDICATION ADMINISTRATION

<p>WASH</p>  <p>AREA & HANDS</p>	<p>UNLOCK</p> 	<p>LOOK</p>  <p>FOR MED BOOK</p>
<p> #1</p> <p>HCP ORDER TO PHARMACY LABEL</p>	<p> #2</p> <p>PHARMACY LABEL TO MED SHEET</p>	<p>PREPARE</p> 
<p> #3</p> <p>PHARMACY LABEL TO MED SHEET</p>	 <p>GIVE</p>	<p>SILENT</p>  <p>LOOK AGAIN</p>
<p>DOCUMENT</p>  <p>MED SHEET COUNT SHEET, IF NEEDED</p>	 <p>LOCK</p>	<p>WASH HANDS</p>  <p>OBSERVE</p> 



Med Pass Instructions

- ❖ **Chip Brown**
- ❖ **8pm med**
- ❖ **Sept. 3, yr**



Giving Multiple Meds

- ❖ **Complete Checks 1 through 3 for each med**
 - **Before moving to next med**
 - **All meds due at the same time for the same individual may be given together**



Med Pass Instructions

- ❖ **Chip Brown**
- ❖ **8am meds**
- ❖ **Sept. 4, yr**



Support Plan PRN Med-Anxiety

Specific behaviors that show us Chip is anxious:

1. Pacing in a circle for more than 4 minutes.
2. Head slapping for longer than 30 seconds or more than 5 times in 4 minutes.
 - A. Staff will attempt to engage Chip in one on one conversation re: current feelings and difficulty.
 - B. Staff will attempt to direct and involve Chip in a familiar activity such as laundry, meal preparation, etc.

If unsuccessful with A or B staff may suggest/offer Chip:

Ativan 0.5mg once daily as needed by mouth. Must give at least 4 hours apart from regularly scheduled Ativan doses.

(Refer to HCP order)

If anxiety continues after the additional dose, notify HCP.

Dr. Smith 9-3-yr

Posted Karen Mason 9-3-yr 2pm

Verified Lisa Long 9-3-yr 6:30p



Med Pass Instructions

- ❖ **Chip Brown**
- ❖ **PRN med for anxiety**
- ❖ **Sept. 4, yr**
- ❖ **3pm**



Med Sheet Documentation

- ❖ **Initials in box that directly corresponds to time & date given**
- ❖ **Initials & signature at bottom**
 - **If first time giving during the month**
- ❖ **PRN medication**
 - **Time/initials in same box**
 - **Medication progress note**



Oral Medication

❖ HCP order required to crush and mix a med with food or liquid





Oral Medication

- ❖ **HCP order required to empty capsule contents**





Oral Medication

❖ **May give half tabs ONLY
if split by pharmacy**





Liquid Med Administration

- ❖ **Place med cup**
 - Flat surface
 - Eye level
- ❖ **Use thumbnail to mark correct measurement**
- ❖ **Shake bottle**
 - If needed
- ❖ **Pour slowly**





Liquid Med Administration

❖ Oral syringe





Liquid Med Administration

❖ Dropper





Other Routes

- ❖ **Never administer a med by any route unless you have received training in that route**





Cautionary Guidelines



- Administering meds if**
- ❖ **Unable to read HCP order**
 - ❖ **Missing any piece of info**
 - ❖ **Unable to read label**
 - ❖ **Label is missing**
 - ❖ **Med was not prepared by you**



Cautionary Guidelines



Administering meds if

- ❖ You have doubts about the 5 rights
- ❖ If person
 - Has a serious change
 - Has difficulty swallowing
 - Refuses
- ❖ Med seems to be tampered with



Medication Refusals





Dealing with Refusals

- ❖ **Offer 3 times**
 - Wait 15-20 minutes
- ❖ **Contact HCP**
 - For recommendation
- ❖ **Notify Supervisor**
- ❖ **Document**



Documenting a Refusal

- ❖ **Circle initials**
- ❖ **Med progress note**
 - **Refusal description**
 - **Who was notified**
 - **HCP**
 - **Recommendation**
 - **Supervisor**



Medication

❖ **What You Need to Know**



Medication

- ❖ Used to treat health problems
- ❖ Taken to eliminate or lessen symptoms
- ❖ Improves quality of life





Medication

- ❖ **Chemicals that enter the body**
 - **Change one or more of the ways the body works**





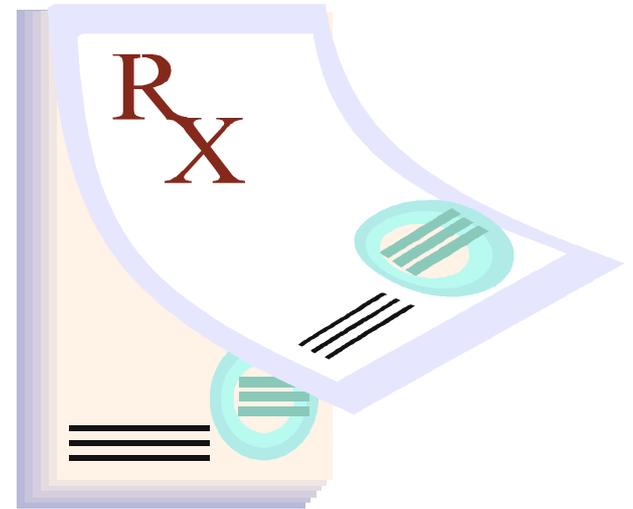
Medication Categories

- ❖ **Prescription**
- ❖ **Over the Counter (OTC)**
- ❖ **Brand name**
- ❖ **Generic name**
- ❖ **Countable substances**



Prescription Medication

- ❖ **Written by HCP**
- ❖ **If uses a small prescription notepad**
 - **May not photocopy to use in place of a HCP order**





OTC Medication

- ❖ **Must have HCP order**
- ❖ **Stored, administered and documented**
 - **As prescription meds**
- ❖ **Medication occurrence**
 - **If not given as ordered by HCP**



Brand Name Medication

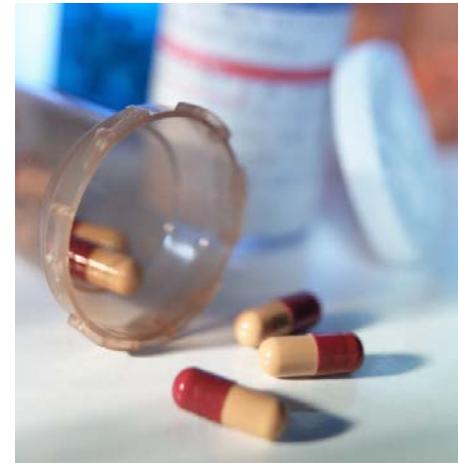
- ❖ **Made by a specific pharmaceutical company**





Generic Medication

- ❖ **Basically same as brand name meds**
- ❖ **Made by different companies**
- ❖ **Usually less expensive**





Countable Substances

❖ Specific Requirements

- Storing
- Packaging
- Tracking
- Counting





Other Substances

❖ Holistic/Herbal Compounds

- Very popular
- HCP order required
- Administered, documented and stored
 - As prescription meds





Holistic/Herbal Compounds

❖ Label requirement options

- Pharmacy
 - Applies label
- Licensed staff verification

Individual's name
written by nurse



Nurses' initials
and date signifies
they have
compared
manufacturer's
label to HCP order



Other Substances

- ❖ Alcohol
- ❖ Nicotine
- ❖ Caffeine





Medication Sensitivity

- ❖ **How a person responds to a med depends on**
 - **Age**
 - **Weight**
 - **Health**



Effects of Medication

Three outcomes

- 1. Desired/Therapeutic Effect**
- 2. No Apparent Desired Effect**
- 3. Unwanted Effects**



Desired Effect

Examples

❖ Tylenol

- Helps a headache

❖ Dilantin

- Helps reduce seizures



No Apparent Desired Effect

Examples

❖ **Could be because it may take more time before full effect of med can occur**

OR

❖ **Even after enough time passes for med to work, it does not**



Unwanted Effects

- ❖ **Meds can cause effects that are not intended or wanted**
 - **Examples**
 - **Side effect**
 - **Allergic reaction**
 - **Anaphylactic reaction**
 - **Paradoxical effect**
 - **Toxicity**



Medication Interaction

❖ **Meds mix in body**

- **May increase or decrease the effect of another med**



Medication Interaction

- ❖ **The more meds taken at one time increases the possibility**
- ❖ **Changes observed could be caused by a med interaction**



Medication Resources

- ❖ **Prescribing HCP**
- ❖ **Pharmacist**
- ❖ **Package inserts**
- ❖ **Reputable online sources**
- ❖ **Medication reference books**



The Cycle of Responsibility



Basic Responsibilities

- ❖ **Observe**
- ❖ **Report**
- ❖ **Document**



Observation

❖ Objective information

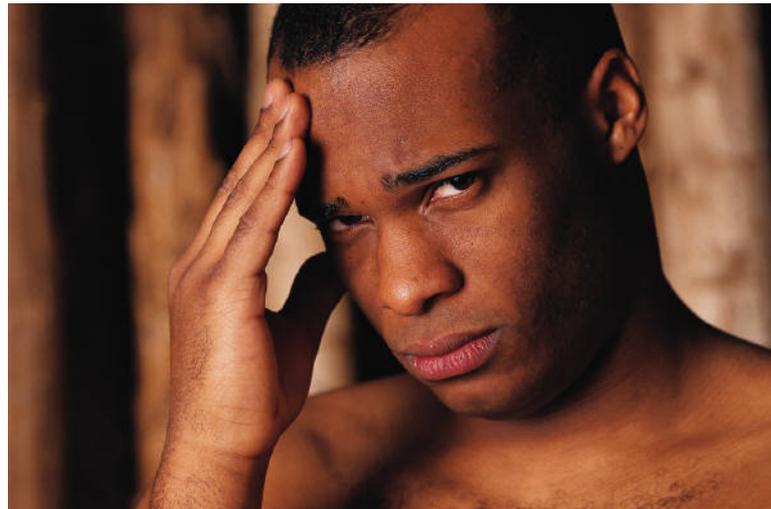
- See
- Hear
- Feel
- Smell
- Measure



Observation

❖ Subjective information

- How a person tells you they feel





Reporting

- ❖ **Immediate**
- ❖ **Certain time**
- ❖ **Routine**



Reporting

❖ If unsure...
REPORT





Reporting Information

- ❖ **Knowing who to report to**
 - **Your responsibility**



Med Pass Instructions

- ❖ **Melissa Sullivan**
- ❖ **8pm meds**
- ❖ **Sept. 3, yr**



Med Pass Instructions

- ❖ **Melissa Sullivan**
- ❖ **8am meds**
- ❖ **Sept. 4, yr**



The Management of Med Administration



Transcription

❖ Info copied from

- HCP order & pharmacy label
 - To med sheet



Documentation

- ❖ **Ink**
- ❖ **Complete**
- ❖ **Accurate**
- ❖ **Clear**
- ❖ **Include**
 - **Date**
 - **Time**
 - **Full name**



Correction

- ❖ **Draw single line**
- ❖ **Write “error”**
- ❖ **Initial**
 - **Do not**
 - **Scribble**
 - **“Mark over”**
 - **Erase**
 - **Use “white out”**



Medication Sheet

Name:

Month/Year:

Allergies:

Dates	Medication	Hour	1	2	3	4	5	6
Start:	Generic:							
	Brand:							
Stop:	Strength:							
	Amount:							
	Dose:							
	Frequency:							
	Route:							

SPECIAL INSTRUCTIONS:

REASON:



Abbreviations

❖ **Safer not to use**





Abbreviations

❖ DC	Discontinue
❖ mg	Milligram
❖ cont	Continue
❖ tab	Tablet
❖ cap	Capsule
❖ mL	Milliliter



Frequency

- ❖ Number of times per day to be given
- ❖ Specific hour chosen

Examples

HOUR
8am
4pm

HOUR
8am
4pm
8pm

HOUR
8am
12pm
4pm
8pm



Discontinue Order

- ❖ Mark **COMPLETELY** through all boxes next to where med was scheduled to be given
- ❖ **Diagonal lines across**
 - **Left section of med sheet**
 - DC, date, initials
 - **Grid**
 - DC, date, initials



Step 1

Month and Year: DECEMBER (year)
 Medication or Treatment

Medication Sheet

Start:	Generic: Clozapine	Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14
12/3/yr	Brand: Clozaril	8am	X	X	X	DS	DS									
Stop:	Strength: 25mg tabs															
Cont.	Amount: 3 tabs Dose: 75mg	4pm	X	X	ES	ES										
	Frequency: 3X/day Route: by mouth	10pm	X	X	ES	ES										

Special Instructions:

Start:	Generic: Amoxicillin	Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14
12/3/yr	Brand: Amoxil	8am	X	X	X	DS	DS	[Redacted]								X
Stop:	Strength: 250mg caps	12pm	X	X	DS	DS	[Redacted]								X	X
12/13/yr	Amount: 2 caps Dose: 500mg	4pm	X	X	ES	ES	[Redacted]								X	X
	Frequency: 4X/day Route: by mouth	8pm	X	X	ES	ES	[Redacted]								X	X

Special Instructions:

Take with meals for 10 days



Step 2

Month and Year: DECEMBER (year)

Medication Sheet

Medication or Treatment

Start:	Generic: Clozapine	Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
12/3/yr	Brand: Clozaril	8am	X	X	X	DS	DS										
Stop:	Strength: 25mg tabs																
Cont.	Amount: 3 tabs Dose: 75mg	4pm	X	X	ES	ES											
	Frequency: 3X/day Route: by mouth	10pm	X	X	ES	ES											

Special Instructions:

Start:	Generic: Amoxicillin	Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15		
12/3/yr	Brand: Amoxil <i>DIC</i>	8am	X	X	X	DS	DS	[Redacted]										X	X
Stop:	Strength: 250mg caps <i>12/5/yr</i>	12pm	X	X	DS	DS	[Redacted]										X	X	X
12/13/yr	Amount: 2 caps Dose: 500mg <i>JW</i>	4pm	X	X	ES	ES	[Redacted]										X	X	X
	Frequency: 4X/day Route: by mouth	8pm	X	X	ES	ES	[Redacted]										X	X	X

Special Instructions:

Take with meals for 10 days



Step 3

Month and Year: DECEMBER (year)

Medication Sheet

Medication or Treatment

Start:	Generic: Clozapine	Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
12/3/yr	Brand: Clozaril	8am	X	X	X	DS	DS										
Stop:	Strength: 25mg tabs																
Cont.	Amount: 3 tabs Dose: 75mg	4pm	X	X	ES	ES											
	Frequency: 3X/day Route: by mouth	10pm	X	X	ES	ES											

Special Instructions:

Start:	Generic: Amoxicillin	Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
12/3/yr	Brand: Amoxil	8am	X	X	X	DS	DS	DIC 12/5/yr									
Stop:	Strength: 250mg caps	12pm	X	X	DS	DS	12/5/yr										
12/13/yr	Amount: 2 caps Dose: 500mg	4pm	X	X	ES	ES	RM										
	Frequency: 4X/day Route: by mouth	8pm	X	X	ES	ES	RM										

Special Instructions:

Take with meals for 10 days



Transcription Workbook One



Worksheet

Dose-Strength-Amount Worksheet

DOSE is found in the Health Care Provider's order

HCP Order Example:

Health Care Provider Order

Chip Brown	no known allergies
Zantac 150mg twice a day by mouth	
HCP's Signature: <i>Dr. Jones</i>	Date: 6/11/yr

(The dose is _____mg)

STRENGTH is found on pharmacy label next to the name of the medication

Pharmacy Label Example:

Rx# 135	ABC Pharmacy 20 Main Street Any Town, MA 09111	555-555-1212 6/11/yr
Chip Brown Ranitidine HCL 75mg I.C. Zantac Take two tablets by mouth two times a day		Qty. 120 Dr. Jones
Lot# 323-5	ED: 6 /11/yr	Refills: 3

(The strength is _____mg)

AMOUNT is found on the pharmacy label in the instructions for administration

(The amount is _____ tabs)



Dose

Found in HCP order, usually in “mg”

Health Care Provider Order	
Chip Brown	No Known Allergies
Zantac 150mg twice a day by mouth	
Signature: <i>Dr. Jones</i>	Date: 6/11/yr

The dose is: ____ mg



Strength & Amount

Found on pharmacy label

Rx# 135

ABC Pharmacy
20 Main Street
Any Town, MA 09111

555-555-1212

Chip Brown

Ranitidine HCL 75mg

I.C. Zantac

Take two tablets by mouth twice a day

6/11/yr

Qty: 120

Dr. Jones

Lot#323-5

ED: 6/11/yr

Refills: 3

The strength per tablet is: ____ mg

The amount of tabs to give: ____ tabs



Transcription Practice

INSTRUCTIONS

You have taken Chip Brown to the doctor and have received medication from the pharmacy. Pretend that the date is June 11, year. It is 1 pm.

Use the health care provider's order, pharmacy label and generic equivalents to discontinue the order and transcribe the new order on to the Medication Sheet.

Please Note: Do not place your initials in the medication box. You are not administering a medication at this time. This is transcription only.

HEALTH CARE PROVIDER ORDER

S
T
A
F
F

Name: Chip Brown	Date: 6/11/yr
Health Care Provider: Dr. Jones	Allergies: no known allergies
Reason for Visit: Chip states he has a burning feeling in his throat during the day.	
Current Medications: Pantoprazole 40mg by mouth every evening	
Staff Signature: <i>John Smith, Program Manager</i>	Date: 6/11/yr

D
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Health Care Provider Findings:	
Medication/Treatment Orders:	
D/C Pantoprazole	
Zantac <u>150mg</u> <u>twice a day</u> by <u>mouth</u> (dose) (frequency) (route)	
Instructions:	
Follow-up visit:	Lab work or Tests:
Signature: <i>Dr. Jones</i>	Date: 6/11/yr

Month and Year: June (year)

MEDICATION ADMINISTRATION SHEET

Allergies: none



Start	Generic Pantoprazole	Hour	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		
2-7-yr	Brand Protonix																																		
	Strength 40mg	Dose	40mg																																
Stop	Amount 1 tab	Route	By mouth																																
Cont.	Frequency Once in the evening	8pm	KB	KB	KB	KB	ST	ST	KB	KB	KB	KB																							

Special instructions:

Reason: decrease acid

Start	Generic	Hour	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		
	Brand																																		
	Strength	Dose																																	
Stop	Amount	Route																																	
	Frequency																																		

Special instructions:

Reason:

Start	Generic	Hour	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		
	Brand																																		
	Strength	Dose																																	
Stop	Amount	Route																																	
	Frequency																																		

Special instructions:

Reason:

Start	Generic	Hour	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		
	Brand																																		
	Strength	Dose																																	
Stop	Amount	Route																																	
	Frequency																																		

Special instructions:

Reason:

Name: Chip Brown Site: Everett Street, Apt. 1A	CODES	Init	Signature	Init	Signature
	DP-day program/day hab.	JS	John Smith		
	LOA-leave of absence	KB	Karl Burke		
	P-packaged	RN	Reggie Newton		
	W-work	ST	Sarah Tourney		
	H-hospital, nursing home, rehab center				
S-school					

Pharmacy Label

Rx#135	ABC Pharmacy 20 Main Street Any Town, MA 09111	555-555-1212
Chip Brown		6/11/yr
Ranitidine HCL 75mg (strength)		
I.C. Zantac		Qty. 120
Take two tablets by mouth twice a day (amount)		Dr. Jones
Lot# 323-5	ED: 6/11/yr	Refills: 3

Generic Equivalents

Brand Name	Generic Equivalent
Zantac	Ranitidine HCL
Loram	Loramine
Loxapril	Loxapriline
Tylenol	Acetaminophen
Amoxil	Amoxicillin

Zantac is a stomach acid reducing medication used to treat and prevent ulcers, to treat GERD (gastro esophageal reflux disorder) and excessive acid secretion conditions.



Medication Administration Sheet

Month and Year: **June (year)**

Medication or Treatment

Start:	Generic: Pantoprazole	Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
2/7/yr	Brand: Protonix																
Stop:	Strength: 40mg																
Cont.	Amount: 1 tab Dose: 40mg																
	Frequency: every eve Route: mouth	8pm	KB	KB	KB	KB	ST	ST	KB	KB	KB	KB					

Special Instructions:

Reason: stomach acid

Start:	Generic:	Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
	Brand:																
Stop:	Strength:																
	Amount: Dose:																
	Frequency: Route:																

Special Instructions:

Reason:



Medication Administration Sheet

Month and Year: June (year)

Medication or Treatment

Start:	Generic: Pantoprazole	Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
2/7/yr	Brand: Protonix																
Stop:	Strength: 40mg																
Cont.	Amount: 1 tab Dose: 40mg																
	Frequency: every eve Route: mouth	8pm	KB	KB	KB	KB	ST	ST	KB	KB	KB	KB					

**DC
6/11/yr
JS**

**DC
6/11/yr
JS**

Special Instructions:

Reason: stomach acid

Start:	Generic:	Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
	Brand:																
Stop:	Strength:																
	Amount: Dose:																
	Frequency: Route:																

Special Instructions:

Reason:



Medication Administration Sheet

Month and Year: June (year)

Medication or Treatment

Start: 2/7/yr Stop: Cont.	Generic: Pantoprazole Brand: Protonix DC Strength: 40mg Amount: 1 tab Dose: 40mg Frequency: every eve Route: mouth	6/11/yr JS	Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	

Special Instructions:

Reason: stomach acid

Start: 6/11/yr Stop: Cont.	Generic: Ranitidine HCL Brand: Zantac Strength: 75mg Dose: 150mg Amount: 2 tabs Route: mouth Frequency: twice a day		Hour	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	

Special Instructions:

Reason:



“Post” HCP Order

- ❖ **Completed for new orders**
- ❖ **After transcribing**
 - Agency may choose certain ink color
- ❖ **Written on HCP order**
 - Under HCP signature
- ❖ **Write**
 - Posted
 - Signature
 - Date
 - Time

HEALTH CARE PROVIDER ORDER

Name: Chip Brown	Date: 6/11/yr
Health Care Provider: Dr. Jones	Allergies: no known allergies
Reason for Visit: Chip states he has a burning feeling in his throat during the day.	
Current Medications: Pantoprazole 40mg by mouth every evening	
Staff Signature: <i>John Smith, Program Manager</i>	Date: 6/11/yr
Health Care Provider Findings:	
Medication/Treatment Orders: D/C Pantoprazole Zantac 150mg twice a day by mouth	
Instructions:	
Follow-up visit:	Lab work or Tests:
Signature: <i>Dr. Jones</i>	Date: 6/11/yr

Posted John Smith 6/11/yr 1pm



Transcription Practice

INSTRUCTIONS

You have taken Chip Brown to the doctor and have received medication from the pharmacy. Pretend that the date is June 20, year. It is 1 pm.

Use the health care provider's order, pharmacy label and generic equivalents to discontinue the order and transcribe the new order on to the Medication Sheet.

Please Note: Do not place your initials in the medication box. You are not administering a medication at this time. This is transcription only.

HEALTH CARE PROVIDER ORDER

Name: Chip Brown	Date: 6/20yr
Health Care Provider: Dr. Jones	Allergies: no known allergies
Reason for Visit: complaint of pressure on forehead, mild fever, dizziness, increase in head slapping behavior	
Current Medications: Synthroid 0.125mg by mouth once a day in the morning	
Staff Signature: <i>Paaba Jones, Program Manager</i>	Date: 6/20/yr
Health Care Provider Findings: sinus infection, elevated blood pressure	
Medication/Treatment Orders: D/C Synthroid Armour Thyroid 30mg by mouth once a day in the morning on an empty stomach Inderal 20mg by mouth once a day in the morning Amoxil 500mg by mouth three times a day for 10 days dose	
Instructions:	
Follow-up visit: 2 weeks	Lab work or Tests:
Signature: <i>Dr. Susan Smith</i>	Date: 6/20/yr

strength

Rx#139	ABC Pharmacy 20 Main Street Any Town, MA 09111	555-555-1212
Chip Brown Armour Thyroid	30mg	6/20/yr
		Qty. 30
Take one tablet daily in the morning on an empty stomach by mouth		Dr. Smith
Lot# 659	ED: 6/20/yr	Refills: 3

Rx#285-97226	ABC Pharmacy 20 Main Street Any Town, MA 09111	555-555-1212
Chip Brown Propranolol	10mg	6/20/yr
I.C. Inderal		Qty. 60
Take two tablets daily in the morning by mouth		Dr. Smith
Lot# 323-334	ED: 6/20/yr	Refills: 3

Rx#285-97227	ABC Pharmacy 20 Main Street Any Town, MA 09111	555-555-1212
Chip Brown Amoxicillin	500mg	6/20/yr
I.C. Amoxil		Qty. 30
Take 1 tablet three times a day for ten days by mouth		Dr. Smith
Lot# 323-335	ED: 6/20/yr	Refills: 0



Answer

Month and Year: June (year)

MEDICATION ADMINISTRATION SHEET

Allergies: none

Start 3-23-yr	Generic	Hour	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				
	Brand Synthroid D/C 6-20-yr PJ	8am	JS	JS	JS	JS	JS	RN	RN	RN	JS	JS	JS	JS	JS	RN	RN	RN	JS	JS	JS	JS	X	X	X	X	X	X	X	X	X	X	X	X			
Stop	Strength 0.125mg	Dose 0.125mg																																			
Cont.	Amount 1 tab	Route By mouth																																			
	Frequency Daily in the morning																																				

Special instructions:

REASON: replace thyroid hormone

Start 6-21-yr	Generic	Hour	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				
	Brand Armour Thyroid	8am	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X															
Stop	Strength 30mg	Dose 30mg																																			
Cont.	Amount 1 tab	Route By mouth																																			
	Frequency Daily in the morning																																				

Special instructions: empty stomach

Reason:

Start 6-21-yr	Generic	Hour	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				
	Brand Inderal	8am	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X															
Stop	Strength 10mg	Dose 20mg																																			
Cont.	Amount 2 tabs	Route By mouth																																			
	Frequency Daily in the morning																																				

Special instructions:

Reason:

Start 6-20-yr	Generic	Hour	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				
	Brand Amoxil	8am	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X												X			
Stop	Strength 500mg	Dose 500mg																																			
6-30-yr	Amount 1 tab	Route By mouth	4pm	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X												X	X			
	Frequency 3 times a day		8pm	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X												X	X			

Special instructions: For 10 days

Reason:

Name: Chip Brown Site: Everett Street, Apt. 1A	CODES	Init	Signature	Init	Signature
	DP-day program/day hab	JS	John Smith		
	LOA-leave of absence	KB	Karl Burke		
	P-packaged	RN	Reggie Newton		
	W-work	ST	Sarah Turrey		
	H-hospital, nursing home, rehab center				
	S-school				



Answer

Month and Year: August (year)

MEDICATION ADMINISTRATION SHEET

Allergies: none

Start	Generic Cefaclor	Hour	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	
7-29-yr	Brand Ceclor D/C 8-1-yr PJ	8am	JS					X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
	Strength 250mg Dose 250mg																																	
Stop	Amount 1 tab Route By mouth																																	
8-5-yr	Frequency Twice a day	8pm					X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X

Special instructions: **For 7 days**

Reason: *urinary tract infection*

Start	Generic Amoxicillin	Hour	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
8-1-yr	Brand Amoxil	8am	X											X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
	Strength 250mg Dose 500mg	12pm	X											X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Stop	Amount 2 caps Route By mouth	4pm											X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
8-11-yr	Frequency Four times a day	8pm											X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X

Special instructions: **For 10 days**

Reason:

Start	Generic	Hour	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	
	Brand																																	
	Strength	Dose																																
Stop	Amount	Route																																
	Frequency																																	

Special instructions:

Reason:

Start	Generic	Hour	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	
	Brand																																	
	Strength	Dose																																
Stop	Amount	Route																																
	Frequency																																	

Special instructions:

Reason:

Name: Jane McCarthy Site: 35 River Way	CODES	Init	Signature	Init	Signature
	DP-day program/day hab	JS	<i>John Smith</i>		
	LOA-leave of absence	KB	<i>Karl Burke</i>		
	P-packaged	RN	<i>Reggie Neaton</i>		
	W-work	ST	<i>Sarah Tourney</i>		
	H-hospital, nursing home, rehab				
	S-school				



Answer

Month and Year: February (year)

MEDICATION ADMINISTRATION SHEET

Allergies: none

Start 2-12-yr Stop 2-17-yr	Generic Amoxicillin	Brand Amoxil	D/C 2-14-yr PJ	Strength 250mg	Dose 250mg	Route By mouth	Frequency Four times a day	Amount 1 tab																										
	Hour	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		
	8am	X	X	X	X	X	X	X	X	X	X	X	X	X	KB	KB					X	X	X	X	X	X	X	X	X	X	X	X	X	X
	12pm	X	X	X	X	X	X	X	X	X	X	X	X	X	KB						X	X	X	X	X	X	X	X	X	X	X	X	X	X
	4pm	X	X	X	X	X	X	X	X	X	X	X	X	X	ST	ST					X	X	X	X	X	X	X	X	X	X	X	X	X	X
8pm	X	X	X	X	X	X	X	X	X	X	X	X	X	ST	ST					X	X	X	X	X	X	X	X	X	X	X	X	X	X	X

Special instructions: **For 5 days**

Reason: *respiratory infection*

Start 2-14-yr Stop 2-19-yr	Generic Erythromycin	Brand EES	Strength 333mg	Dose 666mg	Route By mouth	Frequency Three times a day	Amount 2 tabs																											
	Hour	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		
	8am	X	X	X	X	X	X	X	X	X	X	X	X	X	X							X	X	X	X	X	X	X	X	X	X	X	X	X
	4pm	X	X	X	X	X	X	X	X	X	X	X	X	X							X	X	X	X	X	X	X	X	X	X	X	X	X	X
	8pm	X	X	X	X	X	X	X	X	X	X	X	X	X							X	X	X	X	X	X	X	X	X	X	X	X	X	X

Special instructions: **For 5 days**

Reason:

Start Stop	Generic	Brand	Strength	Dose	Route	Frequency	Amount																													
	Hour	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				
	8am																																			
	4pm																																			
	8pm																																			

Special instructions:

Reason:

Start Stop	Generic	Brand	Strength	Dose	Route	Frequency	Amount																														
	Hour	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					
	8am																																				
	4pm																																				
	8pm																																				

Special instructions:

Reason:

Name: Sam Lopes Site: 35 River Way	CODES	Init	Signature	Init	Signature
	DP-day program/day hab	JS	<i>John Smith</i>		
	LOA-leave of absence	KB	<i>Karl Burke</i>		
	P-packaged	RN	<i>Reggie Newton</i>		
	W-work	ST	<i>Sarah Tourney</i>		
	H-hospital, nursing home, rehab center				
S-school					



Answer

Month and Year: April (year)

MEDICATION ADMINISTRATION SHEET

Allergies: Sulfa Drugs



Start	Generic Carbamazepine	Hour	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	
1-2-yr	Brand Tegretol D/C 4-17-yr PJ	8am	JS	JS	JS	JS	JS	RN	RN	RN	JS	JS	JS	JS	JS	RN	RN	RN	JS	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
	Strength 200mg Dose 400mg																																	
Stop	Amount 2 tabs Route By mouth	4pm	KB	KB	KB	KB	ST	ST	KB	KB	KB	KB	KB	ST	ST	KB	KB	KB	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Cont.	Frequency Three times a day	8pm	KB	KB	KB	KB	ST	ST	KB	KB	KB	KB	KB	ST	ST	KB	KB	KB	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X

Special instructions:

Reason: emotional control

Start	Generic Divalproex	Hour	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	
4-17-yr	Brand Depakote	8am	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X															
	Strength 250mg Dose 750mg																																	
Stop	Amount 3 tabs Route By mouth																																	
Cont.	Frequency Twice a day	8pm	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X																

Special instructions:

Reason:

Start	Generic Divalproex	Hour	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	
4-17-yr	Brand Depakote																																	
	Strength 250mg Dose 500mg																																	
Stop	Amount 2 tabs Route By mouth	4pm	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X																
Cont.	Frequency Daily at 4pm																																	

Special instructions:

Reason:

Start	Generic	Hour	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	
	Brand																																	
	Strength	Dose																																
Stop	Amount	Route																																
	Frequency																																	

Special instructions:

Reason:

Name: Joe Simon Site: 35 River Way	CODES	Init	Signature	Init	Signature
	DP-day program/day hab	JS	John Smith		
	LOA-leave of absence	KB	Karl Burke		
	P-packaged	RN	Reggie Newton		
	W-work	ST	Sarah Turner		
	H-hospital, nursing home, rehab center				
	S-school				



Answer

Month and Year: August (year)

MEDICATION ADMINISTRATION SHEET

Allergies: none

Start 4-10-yr Stop Cont.	Generic Ibuprofen	Hour	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	
	Brand Motrin D/C 8-5-yr PJ	P			J/S 7am	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
	Strength 200mg Dose 400mg	R			KB 2pm	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
	Amount 2 tabs Route By mouth	N			RN 4pm	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Frequency Four times a day	D/C 8-5-yr PJ		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X

Special instructions: **Headache Give with snack** Reason: *Headache discomfort*

Start 8-5-yr Stop Cont.	Generic Acetaminophen	Hour	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	
	Brand Tylenol	P	X	X	X	X																												
	Strength 325mg Dose 650mg	R	X	X	X	X																												
	Amount 2 tabs Route By mouth	N	X	X	X	X																												
Frequency Every 6 hours PRN		X	X	X	X																													

Special instructions: **Headache Call HCP if headache continues after 24 hours** Reason:

Start Stop Cont.	Generic	Hour	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	
	Brand	P																																
	Strength Dose	R																																
	Amount Route	N																																
Frequency																																		

Special instructions: Reason:

Start Stop Cont.	Generic	Hour	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	
	Brand	P																																
	Strength Dose	R																																
	Amount Route	N																																
Frequency																																		

Special instructions: Reason:

Name: Marie Sousa Site: 35 River Way	CODES	Init	Signature	Init	Signature
	DP-day program/day hab	JS	<i>John Smith</i>		
	LOA-leave of absence	KB	<i>Karl Burke</i>		
	P-packaged	RN	<i>Reggie Neaton</i>		
	W-work	ST	<i>Sarah Tourney</i>		
	H-hospital, nursing home, rehab center				
S-school					



Answer

Month and Year: September (year)

MEDICATION ADMINISTRATION SHEET

Allergies: none

+

Start 9-16-yr	Generic Centromonium Brand Centrex Strength 60mg per 3mL Dose 120mg Amount 6mL Route By mouth Frequency Twice a day	Hour	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		
		8am	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X							X	X	X	X	X	X	X	X	X	X	X
Stop 9-21-yr		8pm	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X							X	X	X	X	X	X	X	X	X	X	X	

Special instructions: **For 5 days** **Use special dropper**

Reason:

Start	Generic	Hour	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		
	Brand																																		
	Strength	Dose																																	
Stop	Amount	Route																																	
	Frequency																																		

Special instructions:

Reason:

Start	Generic	Hour	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		
	Brand																																		
	Strength	Dose																																	
Stop	Amount	Route																																	
	Frequency																																		

Special instructions:

Reason:

Start	Generic	Hour	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		
	Brand																																		
	Strength	Dose																																	
Stop	Amount	Route																																	
	Frequency																																		

Special instructions:

Reason:

Name: Chris Star Site: 35 River Way	CODES	Init	Signature	Init	Signature
	DP-day program/day hab	JS	<i>John Smith</i>		
	LOA-leave of absence	KB	<i>Karl Burke</i>		
	P-packaged	RN	<i>Roggie Newton</i>		
	W-work	ST	<i>Sarah Tourney</i>		
	H-hospital, nursing home, rehab center				
	S-school				



Transcribing HCP Orders

Strength (supplied by pharmacy)

Amount (#tabs, caps, teaspoons, etc.)

Dose (mg doctor wants person to receive each time med given)

$$\textit{Strength} \times \textit{Amount} = \textit{Dose}$$



New Orders

- ❖ If the med has not changed but the dose, frequency, or route (or symptoms if PRN) is changed, it is considered a **NEW** order
 - D/C old order
 - Transcribe new order



“Post” HCP Order

- ❖ Completed for new orders
- ❖ After transcribing
 - Agency may choose certain ink color
- ❖ Written on HCP order
 - Under HCP signature
 - Write
 - Posted
 - Signature
 - Date
 - Time



“Verify” HCP Order

- ❖ **Second certified staff double-check**
- ❖ **Written on HCP order**
 - **Under HCP signature**
 - **Write**
 - **Verified**
 - **Signature**
 - **Date**
 - **Time**
- ❖ **May give meds if not verified yet**



Telephone Orders

- ❖ **Check your agency policy**
- ❖ **Remind HCP to call pharmacy**
- ❖ **Posted/Verified twice**
 - **When med is received and transcribed**
 - **After HCP has signed**
- ❖ **Must be signed by HCP**
 - **Within 72 hours**



Sample Order Form

HCP Telephone/Fax Order Form

Date of telephone/ fax order:

Time of telephone/ fax order:

Name of Individual:

Allergies:

Please discontinue:

Please order:

Generic Name:

Brand Name:

Dose:

Frequency:

Route:

Reason for Medication/Change:

Special Instructions/ Precautions (include instructions for common side effects):

What to do if medication is refused/ forgotten:

Date of next lab work (if any):

Physician Name (print):

Staff Signature/Title:

Date:

Post:

Verify:

Physician Signature:

Date:

Post:

Verify:





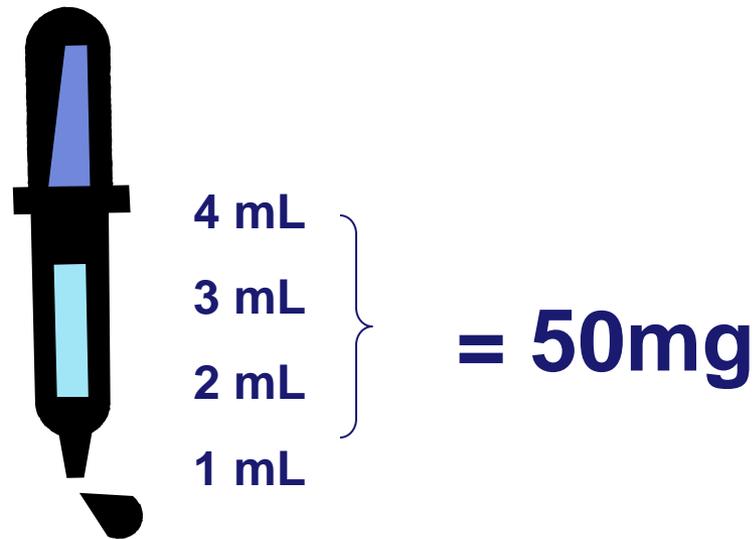
Fax Orders

- ❖ **Legal**
- ❖ **Signed by HCP**
- ❖ **Preferred**



Liquid Med Review

- ❖ HCP: 100mg
- ❖ Label: 50mg per 4mL





Liquid Med Exercises

	Dose	Strength	Amount
1.	150mg	75mg/10mL	_____
2.	100mg	50mg/6mL	_____
3.	100mg	50mg/2mL	_____
4.	150mg	75mg/4mL	_____
5.	200mg	100mg/5mL	_____
6.	150mg	50mg/3mL	_____
7.	100mg	25mg/2mL	_____



The Cycle of Responsibility Continues



Health Care Provider Visits

- ❖ **Advocate**
- ❖ **Respect**
- ❖ **Ask questions**





Information for HCP

- ❖ Reason for visit
- ❖ Allergies
- ❖ Current medications
- ❖ HCP order form
- ❖ Insurance information



Encourage Participation

- ❖ **Redirect HCP to the person**
- ❖ **Encourage person to speak**
 - **Then provide additional info**



Information From HCP

- ❖ **Prescription**
- ❖ **HCP order**
- ❖ **Diagnosis**
- ❖ **What to expect from new med**



Communicating with Pharmacist

❖ HCP can

- Give prescription to
 - Staff person to bring to pharmacy
 - Person to bring to pharmacy
- Send directly by fax or electronically
- Call prescription into pharmacy



Pharmacy Label

Rx#284-9726 Rose Garden Pharmacy 781-555-1231
20 Main Street
Any Town, MA 01969

Freddy Connors 1/1/yr

Amoxicillin 250mg

IC: Amoxil 250mg Qty.-20

Take one tablet twice a day for ten days by mouth.

Drink lots of water when taking.

Lot#323-3333 Exp. Date: 1/1/yr

Dr. T. Smith

Refills: 0



Ensure Pharmacy Provided Right Medication

- ❖ **Compare HCP order with label**
- ❖ **If familiar with med**
 - **Open and look**
- ❖ **If not**
 - **Look up or ask**



Med Pass Instructions

- ❖ **Vi Lee**
- ❖ **8pm med**
- ❖ **Sept. 3, yr**



Med Pass Instructions

- ❖ **Vi Lee**
- ❖ **8am med**
- ❖ **Sept. 4, yr**



Med Pass Instructions

- ❖ **Vi Lee**
- ❖ **4pm med**
- ❖ **Sept. 4, yr**



Med Pass Instructions

- ❖ **Vi Lee**
- ❖ **8pm med**
- ❖ **Sept. 4, yr**



Med Pass Instructions

- ❖ **Vi Lee**
- ❖ **8am med**
- ❖ **Sept. 5, yr**



Countable Substances

- **Countable meds require**
 - **Counting**
 - **Tracking**
 - **Documenting**
 - **Special packaging**
 - **Double-locked storage**



Countable Substance Packaging

- ❖ **Schedule II-V meds must be**
 - **Received from pharmacy**
 - **In tamper resistant packaging**





Countable Substances

Higher incidence of abuse or addiction

Count requirement

- **Each time staff changes, 2 Certified staff count together**

Documentation requiring 2 signatures

1. **When beginning a new count sheet**
2. **Adding a refill onto a count sheet**
3. **Transferring from**
 - **Bottom of old page/top of new page**
 - **An old count book to a new count book**
4. **Disposal**



Count Book

❖ **Must**

- **Be bound**
 - **Pages that cannot be removed**
- **Have**
 - **Preprinted page numbers**
 - **Index**
 - **Count sheets**
 - **Shift count sheets**



Sample Index Page

Name	Medication Name and Strength	Page Number				Signature of person responsible for removing medication from count
Sarah Brown	Phenobarbital 100mg	1	4	7		Karen Mason
Mike Stone	Ativan 1mg	2	5			
Joseph Smith	Ativan 0.5mg	3	6	9	10	See below KM
William Mitchell	Percocet 5/325mg	8				
Joseph Smith	Ativan 0.5mg	11				



Security-Inventory

- ❖ **When entering a new countable in the book or transferring to a new count page**
 - **Complete the heading section of the next available count page**
 - **Do not skip pages**



Sample Count Sheet

Name: Joseph Smith
 Doctor: Paula Whiten
 Pharmacy: Cornerstone
 Medication
 & Strength: Ativan 0.5mg
 Directions: Take 1 tab by mouth every morning
Take 2 tabs by mouth at bedtime

Original Entry
 Transfer from page 10
 Prescription Number: D388857
 Prescription Date: 11/22/yr
 Prescription Number:
 Prescription Date:

Date	Time	Amount on Hand	Amount Used	Amount Left	Signature
12/19/yr	8:00 AM	Transferred	from p. 10	9	Karen Mason / <i>Lisa Long</i>
12/19/yr	8:00 AM	9	One	8	Karen Mason
12/19/yr	8:00 PM	8	Two	6	<i>Lisa Long</i>
12/20/yr	8:00 AM	6	One	5	Karen Mason
12/20/yr	11:00 AM	5	received 60	65	Karen Mason / <i>Reggie Newton</i>
12/20/yr	8:00 PM	65	two	63	<i>Lisa Long</i>



Sample Shift Count Sheet

Date	Time	Count Correct	Staff coming on duty	Staff Going off duty
3/2/yr	8:15am	Yes	Karen Mason	Sarah Torrney
3/2/yr	4pm	Yes	Lisa Long	Karen Mason
3/2/yr	11pm	Yes	Sarah Tourney	Lisa Long
3/3/yr	8am	Yes	Karen Mason	Sarah Tourney
3/3/yr	4:30pm	Yes	Lisa Long	Karen Mason
3/3/yr	11pm	Yes	Sarah Tourney	Lisa Long
3/4/yr	8am	Yes	Karen Mason	Sarah Tourney
3/4/yr	4pm	Yes	Lisa Long	Karen Mason
3/4/yr	11pm	Yes	Sarah Tourney	Lisa Long
3/5/yr	8:15am	Yes	Karen Mason	Sarah Tourney
3/5/yr	4pm	Yes	Lisa Long	Karen Mason
3/5/yr	10:30pm	Yes	Sarah Tourney	Lisa Long
3/6/yr	7am	Yes	Karen Mason	Sarah Tourney
3/6/yr	2pm	Yes	Single Person Count	Karen Mason
3/6/yr	4pm	Yes	Lisa Long	Single Person Count
3/6/yr	11pm	Yes	Sarah Tourney	Lisa Long



Count Sheet Scenario

Name: Joseph Smith
 Doctor: Paula Whiten
 Pharmacy: Cornerstone
 Medication
 & Strength: Ativan 0.5mg
 Directions: Take 1 tab by mouth every morning
Take 2 tabs by mouth at bedtime

Original Entry
 Transfer from page 10
 Prescription Number: D388857
 Prescription Date: 11/22/yr
 Prescription Number:
 Prescription Date:

Date	Time	Amount on Hand	Amount Used	Amount Left	Signature
12/19/yr	8:00 AM	Transferred from p. 10		9	Karen Mason/Lisa Long
12/19/yr	8:00 AM	9	One	8	Karen Mason
12/19/yr	8:00 PM	8	Two	^{Error} 5 6	Lisa Long
12/19/yr	8:00 AM	6	One	5	Reggie Newton
12/20/yr	8:00 AM	6	One	5	Reggie Newton

Error RN



Count Procedure

- ❖ **Count must be done**
 - **Shoulder to shoulder with**
 - **Off-going Certified staff and**
 - **On-coming Certified staff**



Count Procedure

- **On-coming Certified staff has blister packs**
- **Off-going Certified staff has count book**
 - **Leads the count using the index**



Count Procedure

❖ During the count

- Both staff look at blister pack and count book
 - Full legal signatures on shift count verification page



Count Sheet Scenario

Name: Joseph Smith
 Doctor: Paula Whiten
 Pharmacy: Cornerstone
 Medication
 & Strength: Ativan 0.5mg
 Directions: Take 1 tab by mouth every morning
Take 2 tabs by mouth at bedtime

Original Entry
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 Prescription Date:

Date	Time	Amount on Hand	Amount Used	Amount Left	Signature
12/19/yr	8:00 AM	Transferred from p. 10		9	Karen Mason / <i>Lisa Long</i>
12/19/yr	8:00 AM	9	One	8	Karen Mason
12/19/yr	8:00 PM	8	Two	7	<i>Lisa Long</i>
<i>12/20/yr 7am Math on 12/19/yr 8p entry is incorrect. Karen Mason, Supervisor notified. Correct count is 6 left.</i>					
				6	<i>Reggie Newton</i>
12/20/yr	8:00 AM	6	One	5	<i>Reggie Newton</i>



Count Sheet Scenario

Name: Joseph Smith
 Doctor: Paula Whiten
 Pharmacy: Cornerstone
 Medication
 & Strength: Ativan 0.5mg
 Directions: Take 1 tab by mouth every morning
Take 2 tabs by mouth at bedtime

Original Entry
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 Prescription Number:
 Prescription Date:

Date	Time	Amount on Hand	Amount Used	Amount Left	Signature
12/19/yr	8:00 AM	Transferred from p. 10		9	Karen Mason / <i>Lisa Long</i>
12/19/yr	8:00 AM	9	One	8	Karen Mason
12/19/yr	8:00 PM	8	Two	6	<i>Lisa Long</i>
<i>12/20/yr 7:45p Morning dose not subtracted when removed. K. Mason notified. Lisa Long</i>					
12/20/yr	8:00 PM	5	Two	3	<i>Lisa Long</i>
<i>12/21/yr 6a Late entry On 12/20/yr 8a med was given and not documented at that time. Reggie Newton</i>					



Non Suspicious Count Discrepancy

❖ Count is off

- Can be easily resolved by checking
 - Addition
 - Subtraction

❖ Report

❖ Document in count book



Count Discrepancy

- **Count is off**
- **Suspicion of**
 - **Tampering**
 - **Theft**
 - **Unauthorized use of drugs**
- **Report to DPH**



Medication Storage





Medication Storage

- ❖ **Locked/double locked**
- ❖ **Labeled container per person**
 - **Separate oral meds**
 - **From other routes**
 - **Must remain in original packaging**
- ❖ **Refrigerated medications**
 - **Must be locked**



Medication Security

❖ Restricted access

- Two medication key sets
 - One in use
 - Must stay with staff
 - Responsible for med administration
 - Second known only to
 - Administrative staff



Medication Disposal

❖ Purpose

- To make the medication useless



Medication Disposal

❖ When

- Dropped
- Refused
- Expired
- Discontinued
- Person leaves



Disposal Methods

Unless prohibited by local community

- Read the med information sheet first
 - See if there are specific disposal instructions. If not,
 - Take med out of original container
 - Crush and/or dissolve in water in a sealable bag
 - Mix with liquid soap, used coffee grounds or kitty litter
 - Place sealable bag in non descript container
 - Place in trash
- Following disposal remove all identifying personal information from label
- Only flush if the med information sheet provides that as a disposal option



Disposal Process

- ❖ If meds are **expired** or **discontinued**
 - Disposal must be completed with two Certified staff present
 - One must be a Supervisor



Disposal Process

- ❖ If a med is **refused or accidentally dropped**
 - Disposal must be completed with two Certified staff present
 - If unavailable, a supervisor is not required to be present
 - Unless your agency requires it



Required Documentation

- ❖ **DPH Controlled Substance Disposal Record Form for all prescription medication**
 - **Schedule II-VI disposals**
 - **May use for over the counter meds**



DPH Disposal Form

Agency:		Program Site:		DPH Registration #:	
Item #:	Date:	Item #:	Date:	Item #:	Date:
Individual's Name:	Date Last Filled:	Individual's Name:	Date Last Filled:	Individual's Name:	Date Last Filled:
Medication:	Strength:	Medication:	Strength:	Medication:	Strength:
Amount Disposed:	Reason:	Amount Disposed:	Reason:	Amount Disposed:	Reason:
Countable Controlled Substance	Page Number: Rx Number:	Countable Controlled Substance	Page Number: Rx Number:	Countable Controlled Substance	Page Number: Rx Number:
Book Number:	Pharmacy:	Book Number:	Pharmacy:	Book Number:	Pharmacy:
Signatures: Staff:	Supervisor:	Signatures: Staff:	Supervisor:	Signatures: Staff:	Supervisor:
Item #:	Date:	Item #:	Date:	Item #:	Date:
Individual's Name:	Date Last Filled:	Individual's Name:	Date Last Filled:	Individual's Name:	Date Last Filled:
Medication:	Strength:	Medication:	Strength:	Medication:	Strength:
Amount Disposed:	Reason:	Amount Disposed:	Reason:	Amount Disposed:	Reason:
Countable Controlled Substance	Page Number: Rx Number:	Countable Controlled Substance	Page Number: Rx Number:	Countable Controlled Substance	Page Number: Rx Number:
Book Number:	Pharmacy:	Book Number:	Pharmacy:	Book Number:	Pharmacy:
Signatures: Staff:	Supervisor:	Signatures: Staff:	Supervisor:	Signatures: Staff:	Supervisor:
Item #:	Date:	Item #:	Date:	Item #:	Date:
Individual's Name:	Date Last Filled:	Individual's Name:	Date Last Filled:	Individual's Name:	Date Last Filled:
Medication:	Strength:	Medication:	Strength:	Medication:	Strength:
Amount Disposed:	Reason:	Amount Disposed:	Reason:	Amount Disposed:	Reason:
Countable Controlled Substance	Page Number: Rx Number:	Countable Controlled Substance	Page Number: Rx Number:	Countable Controlled Substance	Page Number: Rx Number:
Book Number:	Pharmacy:	Book Number:	Pharmacy:	Book Number:	Pharmacy:
Signatures: Staff:	Supervisor:	Signatures: Staff:	Supervisor:	Signatures: Staff:	Supervisor:

Destruction of all prescription medications in Schedules II -VI that are either out-dated, spoiled or have not been administered due to a change in the prescription or a stop order shall be documented on the DPH approved disposal record. According to regulations at 105CMR 700.003(f)(3)(c): "Disposal occurs in the presence of at least two witnesses and in accordance with any policies at the Department of Public Health". DPH policy requires disposal to occur in the presence of two Certified or licensed staff of which one of the two is supervisory staff. If a supervisor is unavailable when an individual refuses a prepared medication, or a pill is inadvertently dropped then two Certified staff may render these medications unusable in accordance with acceptable DPH disposal practices. Failure to maintain complete and accurate records of drug destruction could result in revocation of your Controlled Substance Registration. Disposal must render the medication unusable and must be in accordance with acceptable DPH disposal practices. Unless prohibited by local ordinance, acceptable practices include, but are not limited to, flushing (flushing should be restricted to those medications so labeled), crushing the medication and/or dissolving in water put into a sealable bag and mixing with an unpalatable substance (such as liquid soap, used coffee grounds, kitty litter). Mixture should then be put into an impermeable, non-descript container, (e.g., detergent bottle) and placed in trash. Medications are not permitted to be returned to the pharmacy for destruction. Medications returned to the program site (e.g., LOAs) must be destroyed as per DPH regulation. They cannot be reused by the program.

10/01/13 Page #



Leave of Absence (LOA)

- ❖ **Pharmacy must prepare meds if**
 - **LOA is planned/scheduled**
 - **Even if under 72 hours**
 - **Person will be away from their residence for more than 72 hours**



Leave of Absence (LOA)

- ❖ **Only if pharmacy cannot**
 - **Certified staff may package meds**
 - **For unplanned LOA**
 - **Less than 72 hours**





Day Program Medication

- ❖ **Residential staff responsibility to provide day program staff with**
 - **Copy of HCP order**
 - **Pharmacy labeled meds**
 - **Notify if a med is DC'd**
 - **Fax DC'd HCP order**



Medication Occurrence (Error)

❖ **One of the 5 rights
went wrong**





Medication Occurrence

❖ Wrong

- Individual
- Medication
- Dose
- Time
 - Includes omission
- Route



Medication Occurrence

- ❖ **Opportunity to improve procedures**
 - That put people at risk
- ❖ **Focus on cause**
 - Rather than who made the mistake



Reporting

❖ Self reporting system





Medication Occurrence

- ❖ **Primary concern**
 - **Safety of the person**



What To Do

- ❖ **Check to see if individual is okay**





What To Do

❖ Know Emergency Procedures





What To Do

- ❖ **Immediately contact MAP Consultant**
 - Read the HCP order
 - Explain what happened
- ❖ **Follow recommendation**
- ❖ **Document**



Medical Intervention

- ❖ **Lab work**
- ❖ **Medical test**
- ❖ **Physician visit**
- ❖ **Clinic visit**
- ❖ **Emergency room visit**
- ❖ **Hospitalization, etc.**



“Hotline” Medication Occurrence

- ❖ **Notify DPH within 24 hours if**
 - ❖ **These follow an occurrence**
 - **Medical intervention**
 - **Illness**
 - **Injury**
 - **Death**



What To Do

❖ **Notify your supervisor**



What To Do

- ❖ **DPH form**
- **Required**
- **In addition to HCSIS data entry**

**Department of Public Health Medication Administration Program
MEDICATION OCCURRENCE REPORT (side one)**

Agency Name		Date of Discovery	
Individual's Name		Time of Discovery	
Site Address (street)		Date(s) of Occurrence	
City/Town Zip Code		Time(s) of Occurrence	
Site Telephone No.		DPH Registration No.	MAP
A) Type Of Occurrence (As per regulation, contact MAP Consultant)			
1 <input type="checkbox"/>	Wrong Individual	4 <input type="checkbox"/>	Wrong Medication (includes medication given without an order)
2 <input type="checkbox"/>	Wrong Dose	5 <input type="checkbox"/>	Wrong Time (includes medication not given in appropriate timeframe)
3 <input type="checkbox"/>	Wrong Route	<input type="checkbox"/> Omission (subgroup of "wrong time"--medication not given or forgotten)	
B) Medication(s) Involved			
	Medication Name	Dosage	Frequency/Time
As Ordered:			
As Given:			
As Ordered:			
As Given:			
As Ordered:			
As Given:			
C) MAP Consultant Contacted (Check all that apply)			
Type	Name	Date Contacted	Time Contacted
<input type="checkbox"/>	Registered Nurse		
<input type="checkbox"/>	Registered Pharmacist		
<input type="checkbox"/>	Health Care Provider		
D) Hotline Events			
Did any of the events below follow the occurrence? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If yes, check all that apply below, and within 24 hours of discovery fax this form to DPH (617) 753-8046 or call to notify DPH at (617) 983-6782 and notify your DMH/DDCF or DDS MAP Coordinator.			
For All Occurrences, forward reports to your DMH/DDCF or DDS MAP Coordinator within 7 days.			
<input type="checkbox"/>	Medical Intervention (see Section E below)	<input type="checkbox"/>	Illness
<input type="checkbox"/>		<input type="checkbox"/>	Injury
<input type="checkbox"/>		<input type="checkbox"/>	Death
E) MAP Consultant's Recommended Action			
Medical Intervention <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Check all that apply.			
<input type="checkbox"/>	Health Care Provider Visit	<input type="checkbox"/>	Lab Work or Other Tests
<input type="checkbox"/>	Emergency Room Visit	<input type="checkbox"/>	Hospitalization
<input type="checkbox"/>	Other: Please describe		
F) Supervisory Review/Follow-up			
Contributing Factors: Check all that apply. If none apply, check none (8)			
1 <input type="checkbox"/>	Failure to Properly Document Administration	5 <input type="checkbox"/>	Medication Had Been Discontinued
2 <input type="checkbox"/>	Medication not Available (Explain Below)	6 <input type="checkbox"/>	Improperly Labeled by Pharmacy
3 <input type="checkbox"/>	Medication Administered by Non-Certified Staff (Includes instances of expired or revoked Certification)	7 <input type="checkbox"/>	Failure to Accurately Record and/or Transcribe an Order
4 <input type="checkbox"/>	Failure to Accurately Take or Receive a Telephone Order	8 <input type="checkbox"/>	None
Narrative: (if additional space is required, continue in box F-1)			
Print Name		Print Title	Date
Contact phone number		E-mail address	

Occurrence Reporting is required by regulation at 105CMR 700.003(F)(1)(f). Consultant Contact is required by regulation at 105CMR 700.003(F)(1)(g). Rev. 2014_12_17



What To Do

- ❖ **Medication Occurrence Report (MOR)**
 - **Documentation**
 - **Paper form and/or**
 - **Data Entry**

