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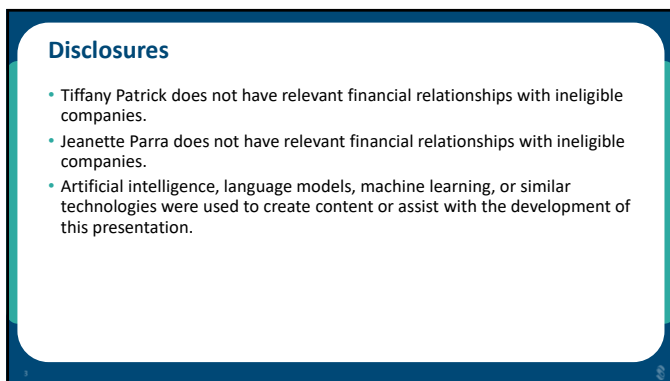
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By the end of this session, you will be able to:

**Objectives**

**01 Safe Administration**  
Apply best practices for medication administration to reduce medication errors and improve patient safety.

**02 Cart Readiness**  
Organize and maintain a medication cart to support efficiency, infection prevention, and audit compliance.

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By the end of this session, you will be able to:

**Objectives**

**03 Preventing Delays**  
Implement strategies to prevent medication delays and ensure timely medication delivery.

**04 Controlled Substances**  
Demonstrate proper management of controlled substances, including storage, documentation, reconciliation, and discrepancy resolution.

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“

*What is the #1 reason med passes run late in your building?*

Scan to answer, or go to [slido.com](https://slido.com) and enter code #2173256

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## Safe Medication Administration

Objective 1

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*1 in 4 doses observed in assisted living had an error*

Young et al., 2008

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### Why Medication Administration Matters



#### Resident Safety

- Prevents medication errors, adverse drug reactions, and potential harm by ensuring the right medication is given to the right resident, at the right dose, time and route.



#### Effective Treatment

- Ensures medications work as intended to manage symptoms, treat illnesses, prevent complications, and improve residents' quality of life



#### Regulatory Compliance and Accountability

- Protects residents' rights, supports accurate documentation, and ensures medications are administered according to professional standards, facility policies and applicable laws

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### The Medication Rights: A Safety Pause

#### Core Verification: every time, 3 times

- ✓ RIGHT resident
- ✓ RIGHT medication
- ✓ RIGHT dose
- ✓ RIGHT route
- ✓ RIGHT time
- ✓ RIGHT documentation

#### Clinical Context

- ✓ RIGHT reason/indication
- ✓ RIGHT assessment
- ✓ RIGHT education
- ✓ RIGHT response
- ✓ RIGHT to refuse
- ✓ RIGHT form

Rights do not replace clinical judgment; they organize it.

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### Before the Medication Pass

Preparation prevents both errors and delays.

- Review new, changed, discontinued, held, and time-sensitive orders before starting.
- Compare the current MAR/eMAR with the pharmacy label and prescriber order when clarification is needed.
- Check allergies, diagnoses, swallowing status and modified-texture diets, and relevant lab/vital-sign parameters.
- Identify medications that are missing, low in supply, refrigerated, controlled, or require special preparation.
- Gather clean equipment; perform hand hygiene; avoid pre-pouring or preparing medications for multiple residents unless specifically permitted by policy and safe practice.

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### 5-Minute Start-of-Shift Scan

- ✓ What is due first?
- ✓ What can cause harm if late?
- ✓ What is missing?
- ✓ What needs assessment?
- ✓ What needs follow-up from prior shift?

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### Verify at the Point of Care

- ID the resident the approved way
- One resident at a time
- Check against the MAR
- Explain the med
- Watch it go down
- Never chart what you didn't give



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*Each interruption raised the risk of a clinical error by about 12.7%. Four or more doubled the risk of a serious one.*

Westbrook et al., 2010

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### Protect the Pass From Interruptions



#### Signal + Education

- A visible "med pass in progress" signal
- Explained to staff and families ahead of time



#### A Time to Come Back

- Post it: "Med pass 8–9 a.m."
- "Non-urgent questions at 9:15"



#### Hold the Non-Urgent

- Route calls and routine tasks to another staff member
- Or hold them until after the pass

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### After Administration: Close the Loop



**Document**

- Chart right after giving it
- Refusals, holds, omissions, late doses
- PRN reason and response



**Monitor**

- Reassess when indicated
- Pain, glucose, BP/HR, sedation, behavior
- Therapeutic and adverse effects



**Communicate**

- Escalate abnormal findings
- Update the next shift
- Hand off pharmacy and family follow-up

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## Medication Cart Readiness

Objective 2

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### Medication Cart Organization



**Security**

- Lock when unattended
- Limit keys/access
- Controlled meds in required storage
- Protect resident-specific meds



**Clean & Separated**

- Clean high-touch surfaces
- Separate oral/topical/eye products
- Supplies clean and dry
- No food or personal items



**Ready to Use**

- Remove expired/discontinued stock
- Date multi-dose products
- Readable labels, consistent layout
- Flag low supply early

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**Audit Readiness: What Reviewers Find**

- ✓ Unlocked cart or med refrigerator; keys accessible
- ✓ Expired, discontinued, damaged, or unidentified medication
- ✓ Missing open dates when required
- ✓ Illegible, altered, or mismatched labels
- ✓ Wrong temperature, or mixed with food/specimens
- ✓ Loose tablets, unlabeled cups/syringes, contaminated supplies
- ✓ MAR exceptions with no explanation
- ✓ Unsigned telephone orders
- ✓ Meds for discharged or deceased residents
- ✓ Gaps in the refrigerator temperature log

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**Shift Audit Habit**

LOOK → LOCK → LABEL → DATE → CLEAN → REORDER → DOCUMENT

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**Preventing Medication Delays**

Objective 3

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*Wrong-time doses are the most common medication error in assisted living*

Young et al., 2008; Zimmerman et al., 2011

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### Preventing Delays: Anticipate

Treat medication availability as a system responsibility.

- Review supply before weekends/holidays
- Order refills early
- Know what auto-refills and what needs a request (short-shelf items, narcotics)
- Ask the pharmacy for a weekly or biweekly refill status report
- Confirm new orders arrived the next morning
- Post the after-hours process where staff can find it

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### Act and Close the Loop

#### Act

- ✓ Search resident-specific approved storage
- ✓ Contact pharmacy promptly
- ✓ Use approved emergency supply when authorized
- ✓ Clarify alternatives with pharmacist/prescriber
- ✓ Never borrow from another resident

#### Close the Loop

- ✓ Document why a dose is late/omitted
- ✓ Notify physician and POA/RP every time
- ✓ Adjust future timing when needed
- ✓ Hand off unresolved delivery issues
- ✓ Track repeated system failures

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### Time-Sensitive Medications

**Watch Closely**

- ✓ Insulin and glucose-lowering therapy
- ✓ Antibiotics: keep intervals
- ✓ Anticonvulsants: avoid gaps
- ✓ Parkinson's: resident-specific timing
- ✓ Anticoagulants: schedule and holds
- ✓ Analgesics, cardiac, others by indication

**If a Dose Is Late**

- ✓ Check when the prior dose was given
- ✓ Assess clinical risk
- ✓ Follow facility timing policy
- ✓ Call pharmacist/prescriber as needed
- ✓ Document the reason and action
- ✓ Re-evaluate future dose timing

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## Controlled Substances

Objective 4

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### Secure, Account, Escalate

  
**Secure**

- Restrict access to authorized personnel
- Secured storage required by law/policy
- Protect keys, codes, and credentials

  
**Account**

- Document receipt, administration, waste, disposition, and balance
- Reconcile records to physical inventory

  
**Escalate**

- Unexplained discrepancy = safety/security event
- Recount, review, notify, preserve evidence, follow policy

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*Can another qualified reviewer reconstruct exactly what happened to every controlled dose, from receipt through final disposition?*

The reconciliation question

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### Count & Reconciliation

- Count together, independently
- Physical count = record
- Check every transaction
- Fix it now
- Never pass it to next shift



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### When the Count Is Wrong

*Act immediately, methodically, and without accusation.*

- 1. STOP, RECOUNT & SEARCH: Secure the medication and independently recount
- 2. VERIFY: Compare MAR/eMAR, controlled log, delivery/return and waste records
- 3. TRACE: Review the last known correct balance and transactions since then
- 4. NOTIFY: Escalate to charge nurse/administrator/pharmacy and others required by policy
- 5. DOCUMENT: Record objective facts, actions, notifications, and resolution; never alter records
- 6. FOLLOW THROUGH: Investigation/reporting and corrective action; preserve evidence and access data; follow facility policy

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### Diversion Prevention

|  Possible Signals                                                                                           |  System Controls                                                                      |  Response Culture                                                                                                |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <ul style="list-style-type: none"> <li>Repeated discrepancies</li> <li>Late/corrected documentation</li> <li>Unusual access or wasting</li> <li>Resident reports meds not working</li> </ul> | <ul style="list-style-type: none"> <li>Restricted access</li> <li>Accurate perpetual records</li> <li>Witnessed waste</li> <li>Access-log review and audits</li> </ul> | <ul style="list-style-type: none"> <li>Report promptly and objectively</li> <li>Protect confidentiality</li> <li>No informal "investigations"</li> <li>Follow HR/regulatory procedures</li> </ul> |

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### Medication Errors & Near Misses

- Resident first: assess immediately and get clinical support
- Notify the clinician, prescriber, pharmacy, leadership, and representative as required
- Document clinical facts in the record; complete the incident report separately
- Monitor for adverse effects and carry out new orders
- Then the system: interruptions, unclear orders, look-alike packaging, staffing, timing, storage, workflow
- Use near misses as learning opportunities before harm occurs

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### “

*Think of a near miss you caught this year. What made it easy to almost happen?*

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Near misses are free lessons

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“

*Shift change: the oxycodone record says 18, the drawer has 17. The med aide who gave the last dose has gone home. What do you do in the next 10 minutes?*

Share your answer: slido.com, code #2173256

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### What You Found

Recount: still 17. The MAR shows a 2 p.m. dose never signed out.

| Is This Resolved?                                                                                                                                                                            | What If No MAR Entry?                                                                                                                                                                                 | Do Not                                                                                                                                                      |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <ul style="list-style-type: none"> <li>Likely documentation, not confirmed</li> <li>Contact the med aide</li> <li>Verify balance; correct per policy</li> <li>Notify and document</li> </ul> | <ul style="list-style-type: none"> <li>Now it's unexplained</li> <li>Secure; notify leadership and pharmacy</li> <li>Preserve records and access logs</li> <li>Follow investigation policy</li> </ul> | <ul style="list-style-type: none"> <li>Alter the count to "make it match"</li> <li>Delay until the next shift</li> <li>Accuse based on suspicion</li> </ul> |

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### Key Takeaways

|                                                                                                                                                                                                                                                                                            |                                                                                                                                                                                                                                                                                                            |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <ul style="list-style-type: none"> <li>✓ Build safety from consistent small actions</li> <li>✓ Prepare early: what's due, high risk, missing</li> <li>✓ Verify at the point of care; assess, don't rely on memory</li> <li>✓ Document what happened; close every exception loop</li> </ul> | <ul style="list-style-type: none"> <li>✓ Storage: secure, labeled, clean, dated, resident-specific</li> <li>✓ Controlled substances: a continuous chain of custody</li> <li>✓ Investigate discrepancies immediately and objectively</li> <li>✓ Use audits and near misses to improve the system</li> </ul> |
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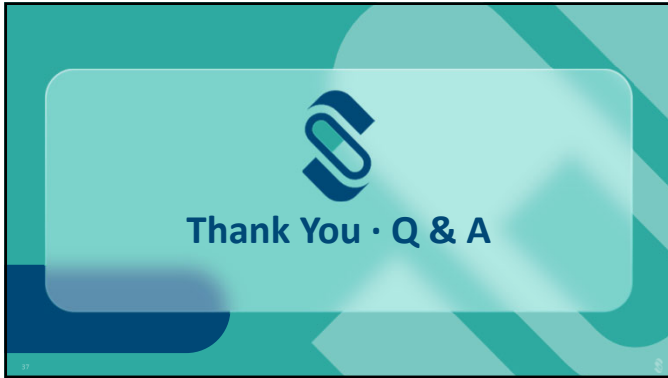
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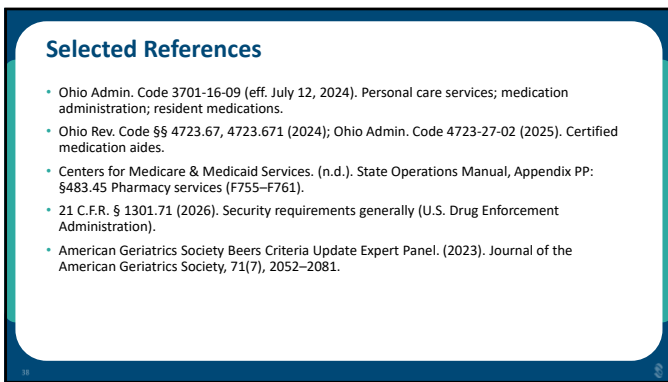
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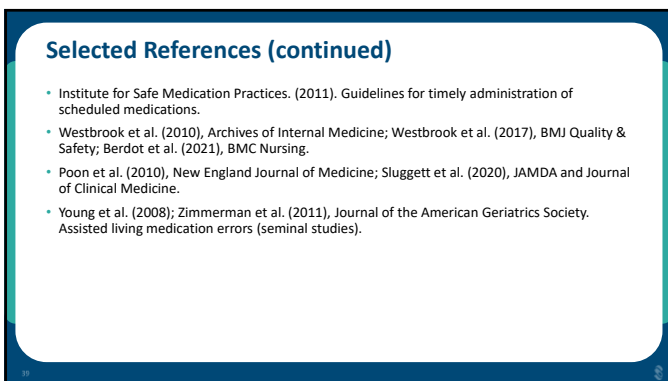
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