LESSON PLAN: 1

COURSE TITLE: MEDICATION TECHNICIAN

UNIT: I INTRODUCTION

SCOPE OF UNIT:

This unit covers course objectives and requirements, the role of the medication technician related to the health care team, and state and federal controls.

INFORMATION TOPIC: I-1 OR DEMONSTRATION:

BECOMING A MEDICATION TECHNICIAN
(Lesson Title)

OBJECTIVES – THE STUDENT WILL BE ABLE TO:

1. List the goals and objectives of the course.

2. List the qualifications of students in the medication technician course.

3. List the methods used to evaluate student performance.

SUPPLEMENTARY TEACHING/LEARNING ITEMS:

1. Samples of evaluation tools (tests, procedure pages, etc.)

INFORMATIONAL ASSIGNMENT:

Read Lesson Plan 1 prior to class and be prepared to discuss the information presented.

INTRODUCTION:

The purpose of this course is to prepare you to become a Certified Medication Technician qualified to administer selected categories of medications to residents of long-term care facilities under the supervision of licensed nursing personnel according to state-approved curriculum.

LESSON PLAN: 1

COURSE TITLE: MEDICATION TECHNICIAN

UNIT: I INTRODUCTION

OUTLINE:

I. Goals and Objectives

A. Prepare, administer, and chart medication by oral, rectal, vaginal, otic, ophthalmic, nasal, topical, and pulmonary routes.

B. Use appropriate infection control measures when administering medications.

C. Observe, record, evaluate, and report responses of residents to medications given.

D. Identify responsibilities associated with control and storage of medications.

E. Identify and utilize appropriate reference materials.

F. Relate common side effects, interactions, and nursing implications of common medications.

G. Identify lines of authority and areas of responsibility.

H. Identify what constitutes a medication error.

II. Student Qualifications

A. High school diploma or GED certificate.

B. A minimum score of 8.9 on both Vocabulary and Comprehension tests and a minimum of 7.0 on Mathematics Concepts and Applications on the Tests on the D level of the Test of Adult Basic Education (TABE) administered by the educational training agency.

C. Six (6) months of employment as a certified nurse assistant (CNA) who is listed as active on the Missouri CNA Registry.

D. For an individual currently employed in a long-term care facility, a letter of recommendation submitted to the educational training agency by the administrator or director of nursing of the facility, or for an individual not currently employed in a long-term care facility, a letter of recommendation submitted to the educational training agency by a previous long-term care employer.

E. The individual is not listed on the department's Employee Disqualification List (EDL) and doe not have a Federal Indicator on the Missouri CNA Registry or any other State's CNA Registry that the educational training agency has checked based on a belief that information on the individual may be included.

F. The individual has not been convicted of or entered a plea of guilty or nolo contendere to a crime in this state or any other state, which if committed in Missouri would be a Class A or Class B felony violation of Chapters 565, 566 or 569, RSMo, or any violation of subsection 3 of section 198.070, or section 568.020, RSMo, unless a good cause waiver has been granted by the department under the provisions of 19 CSR 30-82.060

G. The individual meets the employment requirements listed in 19 CSR 30-85.042 (32). Students who drop the CMT course due to illness or incapacity may reenroll within six (6) months of the date the student withdrew from the course and make up the missed course material upon presenting proof of prior attendance and materials covered if allowed by the educational training agency's policy.

III. Course Evaluation

A. Worksheets.

B. Written tests – to be eligible for the final examination, students shall have achieved a score of at least eighty percent (80%) on each written examination in the course curriculum. The final examination shall include fifty (50) multiple choice questions based on the course objectives accessed through the department's website. A score of at least eighty percent (80%) is required for passing.

C. Classroom discussion.

D. Performance tests – the practicum exam shall include preparing and administering all non-parenteral routes and documenting administration of medications administered to residents. It shall be conducted under the direct supervision of the department approved instructor or examiner and the person responsible for medication administration in the ICF/SNF. Testing on medications not available in the ICF/SNF shall be done in a simulated classroom situation.

E. Drug/medication cards – list a minimum of twenty-five (25) drugs commonly used in a facility and write out their:

1. Brand name.

2. Generic name.

3. Indications.

4. Usual dosage.

5. Precautions.

6. Actions.

7. Contraindications.

8. Warnings/Alerts.

9. Drug interactions.

10. Adverse reactions.

11. Symptoms of overdose.

IV. Summary and Conclusion

A. Goals and objectives.

B. Qualifications of students.

C. Evaluation.

In this lesson, we have explored the purposes and objectives of this course, listed qualifications of students, and outlined how you will be evaluated in this course.

In our next lesson, we will take a look at the health care team of a long-term care facility and its relationship to the medication technician. Take a few minutes to review the organizational structure of a long-term care facility. Can you identify those individuals at your place of employment?

LESSON PLAN: 1

COURSE TITLE: MEDICATION TECHNICIAN

UNIT: I INTRODUCTION

EVALUATION ITEMS:

1. List eight course objectives.

    a.

    b.

    c.

    d.

    e.

    f.

    g.

    h.

2. List three qualifications of students in the medication technician course.

    a.

    b.

    c.

3. List five methods used to evaluate student performance.

    a.

    b.

    c.

    d.

    e.

4. Which of the following is a requirement for students enrolled in the CMT course?

    a. College degree.
    b. 3 years of employment as a certified nurse assistant.
    c. Score of 100% on the TABE test.
    d. CNA in good standing.

LESSON PLAN: 2

COURSE TITLE: MEDICATION TECHNICIAN

UNIT: I INTRODUCTION

SCOPE OF UNIT:

This unit covers course objectives and requirements, the role of the medication technician related to the health care team, and state and federal controls.

INFORMATION TOPIC: I-2 OR DEMONSTRATION:

LONG-TERM HEALTH CARE TEAM
(Lesson Title)

OBJECTIVES – THE STUDENT WILL BE ABLE TO:

1. Trace lines of authority in a sample organizational chart of a long-term care facility.

2. Identify the responsibilities of the long-term health care team which includes the following: Administrator, physician, pharmacist, registered nurse, licensed practical nurse, and medication technician.

3. List six (6) tasks a medication technician may NOT perform.

4. Identify how the legal and ethical issues affect health care personnel.

5. Identify guidelines to follow to avoid medical/legal problems.

6. Identify situations that would constitute a breach in confidentiality of a resident's protected health information (HIPAA).

SUPPLEMENTARY TEACHING/LEARNING ITEMS:

1. HO 1: Organizational Structure – Long-Term Health Care Facility

2. HO 2: Abuse and Neglect Reporting.

3. HO 3: Resident's Rights – State of Missouri.

INFORMATIONAL ASSIGNMENT:

Read Lesson Plan 2 prior to class and be prepared to discuss the information presented.

INTRODUCTION:

The term “health care team” is another way of describing the people who join together to assess, develop plans of care, provide care, and re-evaluate residents who require long-term care. The term illustrates that it takes more than one person to provide optimal health care to any resident or group of residents. In this lesson you will learn who makes up the health care team, their specific responsibilities, and the medical/legal aspects of medication therapy.

LESSON PLAN: 2

COURSE TITLE: MEDICATION TECHNICIAN

UNIT: I INTRODUCTION

OUTLINE:

I. Organizational Structure – Long-Term Health Care Facility (HO 1)

II. Role of the Health Care Team Members Involved in Medication Therapy – governed by state and federal regulations by varying degrees.

NOTE: The organizational structure of a Long Term Care facility may vary from the example provided in this text. The size of the facility and affiliation with a larger healthcare corporation may affect the manner in which the team is set up.

A. Administrator – responsible for all departments within the long term care facility.

1. Responsible for all policies and procedures.

2. Guides the quality assurance process.

3. Responsible for adequate staffing resources.

4. Responsible for lines of accountability.

B. Physician/medical provider – Medical Doctor (MD), Doctor of Osteopathy (DO), Nurse Practitioner (NP), or Physician's Assistant (PA).

1. Performs annual physical exam.

2. Diagnoses the resident.

3. Orders medications and treatments.

C. Pharmacist – allied health professional.

1. Provider role – drug delivery and administration systems. Services include:

a. Labeling.

b. Packaging.

c. Record and audit systems.

d. Accountability of controlled drug supplies and emergency drugs.

2. Consultant role – establish policy concerning drug use, drug regimen review, and in-service education. Services include:

a. Monthly chart review/drug regimen review.

b. Identifying irregularities in drug use.

c. Providing drug information.

d. Serving on committees such as Quality Assurance and Assessment

e. Developing drug use policy.

f. Performing medication pass reviews.

D. Registered Nurse (RN) – allied health professional.

1. Leader of nursing team.

2. Supervises medication technician.

3. Takes and records telephone and verbal orders.

4. Administers parenteral medications.

5. Is an educator.

E. Licensed Practical Nurse (LPN).

1. Supervises medication technician.

2. Takes and records telephone and verbal orders.

3. Administers parenteral medications including IV medications IV certified.

F. Medication technician responsibilities.

1. Meets basic care needs of the residents.

2. Reports and records information related to drug administration.

3. Maintain aseptic conditions by using body substance precautions.

4. Measure vital signs (TPR, B/P, and apical pulse); (refer to CNA manual).

5. Prepare, administer, report, and record medications by the oral, ophthalmic, otic, topical, transdermal patch, respiratory, nasal, vaginal and rectal routes.

6. Safeguard medication preparation and storage area.

7. Count controlled substances (per facility policy).

8. Transcribes orders (per facility policy).

9. Records and removes unused medications from active area.

10. Safeguards medications.

11. Gives simple precautions and directions to residents.

12. Administers oxygen by nasal cannula when the resident has a physician's order for oxygen and after assessment by licensed nurse.

13. Administers inhaled medications using a nebulizer if permitted by facility policy. Due to variances in equipment, the facility must provide the Certified Medication Technician with training on the operation of the nebulizer system(s) being used in the facility prior to their use. Documentation of this training and competency in use of the equipment must be placed in the employee's record.

14. Monitors resident's health status such as vital signs and pain scale scores and reports abnormalities to the licensed nurse.

15. Adheres to facility policies.

NOTE: The Medication Technician may be employed in a Skilled or Intermediate Care facility (SNF/ICF). A CMT cannot set up or administer medications when working in any other setting including but not limited to home care or hospitals.

III. The Medication Technician Does NOT:

A. Inject parenteral drugs with the exception of insulin if insulin certified.

B. Administer bladder instillations.

C. Calculate drug dosages or conversions.

D. Dispose of medications.

E. Administer oxygen by a re-breathing mask or nasal catheter.

F. Administer enteral nutrition, fluids or medications via a feeding tube including but not limited to gastrostomy, jejunostomy, nasogastric (NG) or Nasointestinal (NI) tubes.

IV. Health Care Personnel, Law and Ethics

A. As an employee in the health care occupations, it is important for you to be aware of your legal and ethical responsibilities to prevent medical/legal problems.

B. When you care for residents or have access to their records, you are expected to maintain their confidence and trust. Any violation of the resident's trust and confidence may be defined as an illegal or immoral act.

C. There are certain laws which protect the rights of residents who enter long-term or other health care facilities (HO 2, HO 3). The resident voluntarily signs an admission agreement giving his or her consent for treatment and care.

D. Missouri State Regulations require that each person who has, or may have contact with residents, wear an identification badge while on duty. The badge must give the employee's name, title and if applicable the state of their license or certification as a health care professional. This rule applies to all personnel who provide services to any resident directly or indirectly.

E. Some possible situations for legal problems might be:

1. Assault (threat or harm) – For example telling a resident "If you don't be quiet, I'll tie your hands down."

2. Restraining a resident – All restraints require a physician's order. They are used only as a last resort when the resident could harm himself or others.

3. Gossiping about residents may be defined as "defamation of character" or "defamation by slander."

4. A written entry in a chart such as "the resident was a cross old crackpot today" could be defined as written defamation and "libel."

5. Personal information about residents comes under the classification of "privileged information." Talking about a resident with or around others not directly involved in the resident's care violates the resident's right to confidentiality.

6. In the long-term care facility, a surveyor may want to look at resident's skin. Without the resident's consent or proper screening, this could be an "invasion of privacy."

7. Performing procedures outside the scope of practice of a medication technician or performing procedures that you have not been trained to perform.

8. Documenting procedures or medications prior to actually performing the procedure or administering the medications.

F. As a health care worker, you must become familiar with legal and ethical terms that will assist you in understanding your responsibility and help you uphold your resident's rights.

G. Legal documents or records are accepted in the courts of law as evidence of truth. A resident's chart is a legal document or record. The "signed consent" is a legal record, just as a will is a legal document. The consent must be voluntarily signed in ink by a resident of sound mind. The signing must be witnessed by at least two persons aged 21 or over.

V. Guidelines to Avoid Medical/Legal Problems

1. Maintain good relationships with residents, family members and coworkers.

2. Remember that the resident is your responsibility.

3. Observe the resident's rights and avoid violating them.

4. Prepare all paper work accurately and in a timely manner according to facility policy.

5. Know your lines of authority. Do only those things which you have been trained and supervised to do. Seek assistance from your charge nurse if you are in doubt.

6. Be familiar with and follow facility and pharmacy policies and procedures.

VI. Summary and Conclusion

A. Organizational structure.

B. Responsibilities of the team members involved in medication therapy.

C. Tasks a medication technician may NOT perform.

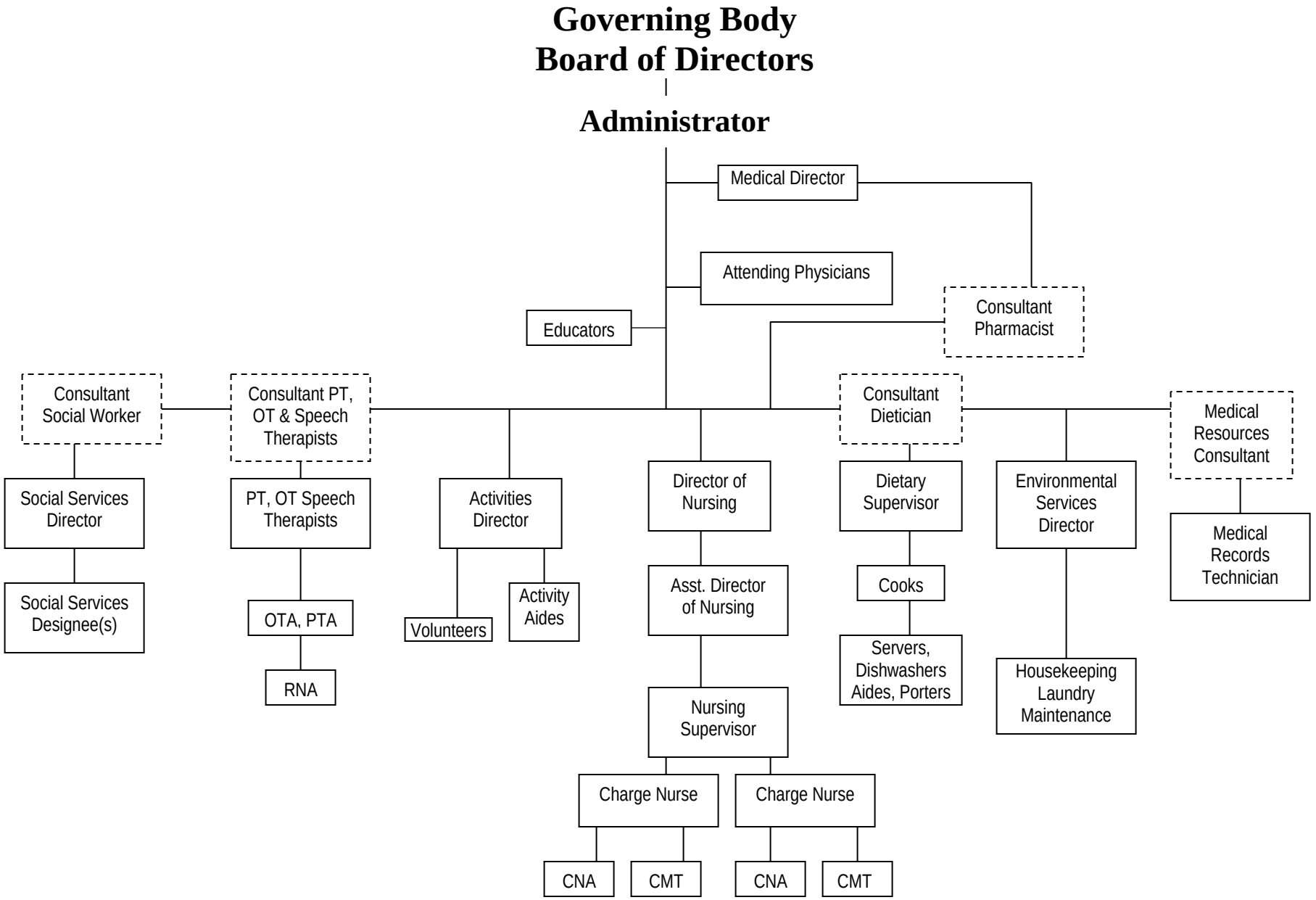
D. Medical/Legal terminology.

E. Legal and ethical issues affecting health care personnel.

F. Guidelines to avoid medical/legal problems.

The next lesson is on state and federal controls.

ORGANIZATIONAL STRUCTURE OF A LONG-TERM CARE FACILITY



ABUSE AND NEGLECT REPORTING

The following is a summary of the Omnibus Nursing Home Act in Section 198.070. It is only a summary of key points specific to the instructor and student of this manual for use in long-term care facilities. For a complete reference, refer to the Missouri Code of State Statues at 198.070.

When any long term care facility employee has reasonable cause to believe a resident has been abused or neglected or financially exploited, the employee shall immediately report or cause a report to be made to the Department of Health and Senior Services.

The report shall contain the name and address of the facility, the name of the resident, information regarding the nature of the abuse or neglect, the name of the person making the complaint, and any other information, which might be helpful in an investigation.

Anyone who fails to make a report or cause a report to be made within a reasonable time after the act of abuse or neglect is guilty of a class (A) misdemeanor.

When the Department of Health and Senior Services receives a report, the department will begin an investigation with in twenty-four hours. The department will notify the resident's next of kin or responsible party of the report and the investigation and will further notify them whether the report was substantiated or unsubstantiated. The department will report substantiated abuse to the appropriate law enforcement agency and prosecutor.

If the investigation indicates possible abuse or neglect of a resident, the investigator shall refer the report to the department director for appropriate action. If the department has reasonable cause to believe that immediate removal is necessary to protect the resident from abuse of neglect, the department will seek to protect the resident by petitioning to have the resident removed for temporary care and protection.

Reports shall be confidential.

Anyone, except any person who has abused or neglected a resident in a facility, who makes a report or who testifies in any administrative or judicial proceeding shall be immune from any civil or criminal liability for making such a report or for testifying. It is a crime for any person to purposefully file a false report of elder abuse or neglect.

Within five working days of making the report, the reporter will receive notice that the investigation was initiated.

No person who directs or exercises any authority in a facility shall evict, harass, dismiss or retaliate against a resident, family member or employee who makes an abuse or neglect report to the department. If the reporter has reasonable cause to believe retaliation is being committed against him or her, the department shall provide information about their rights, protections, and options in these cases.

Any person who abuses or neglects a resident of a facility is subject to criminal prosecution.

The department shall maintain the Employee Disqualification List (EDL) and shall place the names of any persons who are or have been employed in any facility and who have been found to have knowingly or recklessly abused or neglected a resident. A person acts "knowingly" with respect to the person's conduct when a reasonable person should be aware of the result caused by his or her conduct. A person acts "recklessly" when the person consciously disregards a substantial or justifiable risk that the person's conduct will results in serious physical injury and such disregard constitutes a gross deviation from standard of care that a reasonable person would exercise in the situation.

The Missouri Department of Health and Senior Services Elder Abuse and Neglect Hotline phone number is (800) 392-0210.

RESIDENTS RIGHTS - STATE OF MISSOURI

Title 13 - DEPARTMENT OF HEALTH AND SENIOR SERVICES
Division 30 - Division of Health Standards and Licensure
Chapter 88 – Resident's Rights and Handling Resident Funds and Property in Long-Term Care Facilities

19 CSR 30-88.010 - effective August 28, 2001; amended: filed March 1, 2004 - effective Oct. 30, 2004.

NOTE: Underlined regulations are specific to the duties and responsibilities of certified medication technicians. I, II, and III refer to the class of deficiencies. Class I deficiencies are the violation of which would present either imminent danger to the health, safety, or welfare of any resident, death or serious harm. Class II deficiencies are violations which have a direct or immediate relationship to the health, safety, or welfare of any resident but does not create imminent danger. Class III is deficiencies that have an indirect or a potential impact on any resident.

Requirements for all types of Licensed Long-Term Care Facilities.

The resident has the:

1. The facility shall retain and make available for public inspection at the facility to facility personnel, residents, their families or legal representatives and the general public, a list of names, addresses and occupations of all individuals who have a property interest in the facility as well as a complete copy of each official notification from the Division of Aging of violations, deficiencies, licensure approval, disapprovals, or a combination of these, and responses. This includes, as a minimum, statements of deficiencies, copies of plan(s) of correction, acceptance, or rejection notice regarding the plan(s) of corrections and revisit inspection report. II/III

2. Any notice of noncompliance shall be posted in a conspicuous location along with a copy of the most recent inspection reports, as required by section 198.026(6), RSMo. II/III

3. A copy of the most current Division of Aging rules governing the facility shall be kept available and easily accessible in the facility for review by residents, their families, legal guardians and the public. II/III

4. Each resident admitted to the facility, or his/her guardian or legally qualified representative, shall be fully informed of his/her rights and responsibilities as a resident. These rights shall be reviewed annually with each resident, guardian or legally qualified representative, either in a group session or individually.

5. All incoming and present residents in a facility shall be provided statements of resident rights along with rules governing conduct and responsibilities in a manner

which effectively communicates, in terms the resident can reasonably be expected to understand, those rights and responsibilities. II/III

6. The facility shall document the disclosure of resident's rights information to the resident or his/her legal guardian. III

7. Information regarding resident rights and facility rules shall be posted in a conspicuous location in the facility and copies shall be provided to anyone requesting this information. Informational documents which contain, but are not limited to, updated information on selecting an Alzheimer's special care unit or program shall be given by a facility offering to provide or providing these services to any person seeking information about or placement in an Alzheimer's special care unit or program. III

8. Prior to or at the time of admission and during his/her stay in the facility, each resident shall be fully informed, in writing, of services available in the facility and of related charges, including any charges for services not covered by the facility's basic per-diem rate or federal or state programs. Information shall include procedures to be followed by the facility in cases of medical emergency, including transfer agreements and costs. All residents who receive treatment in an Alzheimer's special care program or unit and their next of kin, designee, legally qualified representative or guardian shall be given a copy of the Alzheimer's Special Care Services Disclosure Form at the time of admission. Residents also shall be informed of services outside the facility which may reasonably be made available to the resident and of any reasonable estimate of any foreseeable costs connected with those services. II/III

9. Prior to or upon admission, each prospective resident or each resident shall be informed of the home and community based services available in this state by providing such resident a copy of the most current Missouri's Guide to Home and Community Based Services, incorporated by reference, or any successor pamphlet as may be incorporated by reference in a subsequent amendment to this section. III

10. Prior to or upon admission and at least annually after that, each resident or guardian shall be informed of facility policies regarding provision of emergency and life sustaining care, of an individual's right to make treatment decisions for him/herself and of state laws related to advance directives for health-care decision making. The annual discussion may be handled either on a group or on an individual basis. Family members or other concerned individuals also shall be informed, upon request, regarding state laws related to advance directives for health-care decision making as well as the facility's policies regarding the provision of emergency or life-sustaining medical care or treatment. If a resident has a written advance health-care directive, a copy shall be placed in the resident's medical record and reviewed annually with the resident unless, in the interval, he/she has been determined incapacitated, in accordance with section 475.075 or 404.825, RSMo. Residents' guardians or health care attorneys-in-fact shall be contacted annually to assure their accessibility and understanding of the facility policies regarding emergency and life-sustaining care. II/III

11. A physician shall fully inform each resident of his/her health and medical condition unless medically contraindicated. If the physician determines the resident's medical condition contraindicates his/her being fully informed of his/her diagnosis, treatment or any known prognosis, the medical record shall contain documentation and justification of this signed by the physician. If there is a legally authorized representative to make health-care decisions, that person shall be fully informed of the resident's medical condition and shall have free access to the resident's medical records for that purpose, subject to the limitations provided by the power of attorney or any federal law. I/II

12. Each resident shall be afforded the opportunity to participate in the planning of his/her total care and medical treatment, to refuse treatment and to participate in experimental research only upon his/her informed written consent. If a resident refuses treatment, this refusal shall be documented in the resident's record and the resident, legal guardian, or both, shall be informed of possible consequences of not receiving treatment. II

13. Each resident shall have the privilege of selecting his/her own physician who will be responsible for the resident's total care. II

14. No resident shall be transferred or discharged except in the case of an emergency discharge unless the resident, the next of kin, the legal representative, the attending physician and the responsible agency, if any, are notified at least thirty (30) days in advance of the transfer or discharge, and casework services or other means are utilized to assure that adequate arrangements exist for meeting the resident's needs. II

15. A resident may be transferred or discharged only for medical reasons or for his/her welfare or that of other residents, or for nonpayment for his/her stay. II

16. No resident may be discharged without full and adequate notice of his/her right to a hearing before the Department of Social Services and an opportunity to be heard on the issue of whether his/her discharge is necessary. Such notice shall be given in writing no less than thirty (30) days in advance of the discharge except in the case of an emergency discharge and must comply with the requirements set forth in 19 CSR 30-82.050. II/III

17. In emergency discharge situations a written notice of discharge and right to a hearing shall be given as soon as practicable. II/III

18. A room transfer of a resident within a facility, except in an emergency situation, requires consultation with the resident as far ahead of time as possible and shall not be permitted where this transfer would result in any avoidable detriment to the resident's physical, mental, or emotional condition. II/III

19. Each resident shall be encouraged and assisted, throughout his/her period of stay, to exercise his/her rights as a resident and as a citizen and to this end a resident may voice grievances and recommend changes in policies and services to facility personnel or to outside representatives of his/her choice. A staff person shall be

designated to receive grievances and the residents shall be free to voice their complaints and recommendations to the staff designee, an ombudsman or to any person outside the institution. Residents shall be informed of and provided a viable format for recommending changes in policy and services. The facility shall assist residents in exercising their rights to vote. II/III

20. The exercise of resident rights shall be free from restraint, interference, coercion, discrimination or reprisal. II/III

21. Each resident shall be free from mental and physical abuse. I

22. The resident has the right to be free from any physical or chemical restraint except as follows:

    (A) When used to treat a specified medical symptom as a part of a total program of care to assist the resident to attain or maintain the highest practicable level of physical, mental or psychosocial well-being. The use of restraints must be authorized in writing by a physician for a specified period of time; or

    (B) When necessary in an emergency to protect the resident from injury to him/herself or to others, in which case restraints may be authorized by professional personnel so designated by the facility. The action taken shall be reported immediately to the resident's physician and an order obtained which shall include the reason for the restraint, when the restraint may be removed, the type of restraint and any other actions required. When restraints are indicated, only devices that are the least restrictive for the resident and consistent with the resident's total treatment program shall be used. I/II

23. In a residential care facility I or II, if it is ever necessary to use a restraint in case of emergency, the resident shall be reevaluated immediately for appropriateness of placement and transferred if necessary. II/III

24. All information contained in a resident's medical, personal or financial record and information concerning source of payment shall be held confidential. Facility personnel shall not discuss aspects of the resident's record or care in front of persons not involved in the resident's care or in front of other residents. Written consent of the resident or legal guardian shall be required for the release of information to persons not otherwise authorized by law to receive it. II/III

25. Each resident shall be treated with consideration, respect and full recognition of his/her dignity and individuality, including privacy in treatment and care of his/her personal needs. All persons, other than the attending physician, the facility personnel necessary for any treatment or personal care, or the Division of Aging or Department of Mental Health staff, as appropriate, shall be excluded from observing the resident during any time of examination, treatment or care unless consent has been given by the resident. II/III

26. No resident shall be required to perform services for the facility. If the resident desires and it is not contraindicated by his/her physician, the resident may perform tasks or services for him/herself or others. II/III

27. Each resident shall be permitted to communicate, associate and meet privately with persons of his/her choice whether on the resident's initiative or the other person's initiative, unless to do so would infringe upon the rights of other residents. The person(s) may visit, talk with and make personal, social or legal services available, inform residents of their rights and entitlements by means of distributing educational materials or discussions, assisting residents in asserting their legal rights regarding claims for public assistance, medical assistance and Social Security benefits and engaging in any other methods of assisting, advising and representing residents so as to extend to them the full enjoyment of their rights. The facility, however, may place reasonable limitations on solicitations. II/III

28. The facility shall permit a resident to meet alone with persons of his/her choice and provide an area which assures privacy. II/III

29. Telephones appropriate to the residents' needs shall be accessible at all times. Telephones available for residents' use shall enable all residents to make and receive calls privately. II/III

30. If the resident cannot open mail, written consent by the resident or legal guardian shall be obtained to have all mail opened and read to the resident. II/III

31. Each resident shall be permitted to participate, as well as not participate, in activities of social, religious or community groups at his/her discretion, both within the facility, as well as outside the facility, unless contraindicated for reasons documented by physician in the resident's medical record. II/III

32. Each resident shall be permitted to retain and use personal clothing and possessions as space permits. Personal possessions may include furniture and decorations in accordance with the facility's policies and shall not create a fire hazard. The facility shall maintain a record of any personal items accompanying the resident upon admission to the facility, or which are brought to the resident during his/her stay in the facility, which are to be returned to the resident or responsible party upon discharge, transfer or death. II/III

33. Each married resident shall be assured privacy for visits by his/her spouse. II/III

34. If both husband and wife are residents, they shall be allowed the choice of sharing or not sharing a room. III

35. Each resident shall be allowed the option of purchasing or renting goods or services not included in the per diem or monthly rate from a supplier of his/her own choice, provided the quality of goods or services meets the reasonable standards of the facility. Freedom of choice of pharmacy shall be permitted provided the facility's policy and procedures for packaging specifications are met. II/III

36. Residents shall not have their personal lives regulated or controlled beyond reasonable adherence to meal schedules and other written policies which may be necessary for the orderly management of the facility and the personal safety of the residents. II

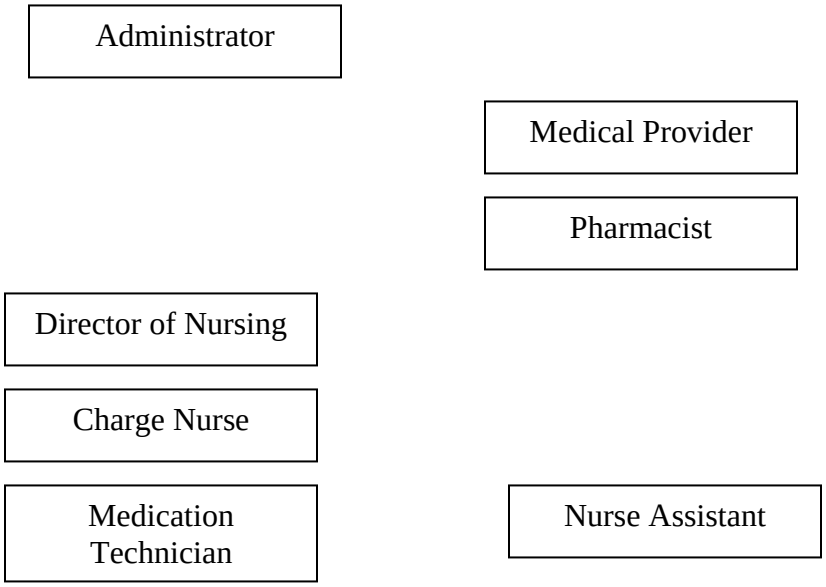
LESSON PLAN: 2

COURSE TITLE: MEDICATION TECHNICIAN

UNIT: I INTRODUCTION

EVALUATION ITEMS:

1. Trace the lines of authority.



Match the following occupations and primary responsibilities.

____ 2.	Leads the nursing team.	a.	Medication Technician
____ 3.	Gives orders to initiate drug therapy.	b.	Pharmacist
____ 4.	Labels and packages medications.	c.	Medical Provider
____ 5.	Prepares and administers non-parenteral medications only.	d.	Registered Nurse
		e.	Administrator
____ 6.	Is responsible for all departments in the facility.		

Circle the letter of the best answer.

7. Who would you contact first if you have a question about a resident's reaction to a medication?

   a. Certified Nurse Assistant.
   b. Pharmacist.
   c. Physician.
   d. Charge Nurse.

8. Select the statement that includes responsibilities the medication technician CANNOT do.

    a. Prepares and administers oral medications, transcribes orders, and inventories drugs.
    b. Safeguards medications, maintains aseptic technique, and administers eye drops.
    c. Administers oxygen by re-breathing mask, injects parenteral drugs, administers bladder instillations, and disposes of medications.
    d. Applies ointments, records drugs administered, reports information related to drug administration, and reorders medication from the pharmacy.

9. Telling a resident “If you don’t be quiet, I’ll tie your hands down” is an example of____ .

    a. assault
    b. defamation of character
    c. libel
    d. invasion of privacy

10. Which of the following guidelines will help you to avoid medical/legal problems?

    a. remembering that the resident is the nurse’s responsibility
    b. violating resident rights
    c. performing any task the resident or family asks you to
    d. being familiar with facility and pharmacy policies and procedures

LESSON PLAN: 3

COURSE TITLE: MEDICATION TECHNICIAN

UNIT: I INTRODUCTION

SCOPE OF UNIT:

This unit covers course objectives and requirements, the role of the medication technician related to the health care team, and state and federal controls.

INFORMATION TOPIC: I-3 OR DEMONSTRATION:

STATE AND FEDERAL CONTROLS
(Lesson Title)

OBJECTIVES – THE STUDENT WILL BE ABLE TO:

1. Match terms related to the medication technician from state regulations to their definitions.

2. Identify the state regulations related to drug administration.

3. Identify key points in the state regulations related to drug administration.

4. Identify what must be included on medication records.

5. Identify the two federal regulations related to drug administration.

SUPPLEMENTARY TEACHING/LEARNING ITEMS:

1. 13 CSR 15-14: Intermediate Care and Skilled Nursing Facility.

2. HO 4: Construction Standards and Physical Plant Requirements for Medication Rooms and Oxygen Storage.

3. HO 5: Excerpts from Missouri's Pharmacy Law.

4. HO 6: Excerpts from Missouri's Nurse Practice Acts.

5. HO 7: Schedules of Controlled Substances.

6. Excerpts from Federal Regulations (OBRA) for Skilled Nursing Facilities (SNFs) and Nursing Facilities (NFs).

INFORMATIONAL ASSIGNMENT:

Read Lesson Plan 3 prior to class and be prepared to discuss the information presented.

INTRODUCTION:

The guidelines for medication administration in the long-term care facility are dictated by state and federal regulations. An overview of these regulations and specific points in state regulations will be discussed.

LESSON PLAN: 3

COURSE TITLE: MEDICATION TECHNICIAN

UNIT: I INTRODUCTION

OUTLINE:

I. Definitions Pertaining to the Medication Technician from State Regulations

A. Certified Medication Technician – shall mean a nursing assistant who has completed a course in medication administration approved by the Department of Health & Senior Services.

B. Chemical restraint – shall mean any medication that is used for discipline or convenience and not required to treat medical symptoms. For the purpose of this definition, discipline means any action taken by the facility for the purpose of penalizing a resident and convenience means any action take by the facility to control a resident's behavior or maintain a resident with a lesser amount of effort by the facility and not in the resident's best interest.

C. Control of medication – shall mean assuming responsibility by the facility for all facets of control of medication including, but not limited to, acquisition, storage, security, and administration.

D. Premises – shall mean any structure or structures that are in close proximity one to the other and which are located on a single piece of property.

E. Self administration of medication – shall mean the act of actually taking or applying medication to oneself.

F. Self control of medication – shall mean assuming immediate responsibility by a resident for the storage and administration of medication for oneself while the facility retains ultimate control of medication.

II. State Regulations Related to Drug Administration

A. Missouri Nursing Home Licensure Law and Regulations.

B. Missouri Pharmacy Practice Act.

C. Missouri Nurse Practice Act.

D. Missouri Controlled Substances Act.

III. What Medications Records Must Include

A. Resident's full name

B. Name of physician

C. Allergies

D. Date.

E. Time.

F. Dosage.

G. Method of administration.

H. Sites of all injections (if insulin certified).

I. Reason for administering PRN medications.

J. Outcome of PRN medications.

K. Omissions of doses.

1. Date.

2. Time.

3. Reason.

4. Effect on resident if known.

IV. Federal Regulations

A. Federal Regulations for Skilled Nursing Facilities and Nursing Facilities.

B. Federal Controlled Substances Act.

It is essential that the medication technician be familiar with and be able to locate and refer to the regulations pertaining to medication administration. The next lesson is on medication terminology and abbreviations.

Division 15-Division of Health & Human Services
Chapter 14 - Intermediate Care and Skilled Nursing Facility

19 CSR 30-85.042 Administration and Resident Care Requirements for New and Existing Intermediate Care and Skilled Nursing Facilities

PURPOSE: This rule establishes standards for administration and resident care in an intermediate care or skilled nursing facility.

PUBLISHER'S NOTE: The publication of the full text of the material that the adopting agency has incorporated by reference in this rule would be unduly cumbersome or expensive. Therefore, the full text of that material will *be made available to any interested person at both the Office of the Secretary of State and the office of the adopting agency, pursuant to section 536.031.4, RSMo. Such material will be provided at the cost established by state law.*

Editor's Note: <u>underlined regulations</u> are specific to the duties and responsibilities of certified medication technicians. I, II, and III refer to the class of deficiencies. Class I deficiencies are the violation in which would present either imminent danger to the health, safety, or welfare of any resident, death or serious harm. Class II deficiencies are violations which have a direct or immediate relationship to the health, safety, or welfare of any resident but does not create imminent danger. Class III is deficiencies that have an indirect or a potential impact on any resident.

(1) The operator shall designate a person as administrator who holds a current license as a nursing home administrator in Missouri. II

(2) The facility shall post the administrator's license. III

(3) The operator shall be responsible to assure compliance with all applicable laws and rules. The administrator shall be fully authorized and empowered to make decisions regarding the operation of the facility and shall be held responsible for the actions of all employees. The administrator's responsibilities shall include the oversight of residents to assure that they receive appropriate nursing and medical care. II/III

(4) The administrator shall be employed in the facility and serve in the capacity on a full-time basis. An administrator cannot be listed or function as an administrator in more than one (1) licensed facility at the same time, except that one (1) administrator may serve as the administrator of more than one (1) licensed facility if all facilities are on the same premises. II/III

(5) The licensed administrator shall not leave the premises without delegating the necessary authority in writing to a responsible individual. If the administrator is absent from the facility for more than thirty (30) consecutive days the person designated to be administrative charge shall be a currently licensed nursing home administrator. Such thirty (30) consecutive-day absences may only occur once within any consecutive twelve (12)-month period. I/II

(6) The facility shall not knowingly admit or continue to care for residents whose needs cannot be met by the facility directly or in cooperation with outside resources. Facilities which retain residents needing skilled nursing care shall provide licensed nurses for these procedures. IIII

(7) When outside resources are used to provide services to the resident, the facility shall enter into a written agreement with each resource. III

(8) Persons under seventeen (17) years of age shall not be admitted as residents to the facility unless the facility cares primarily for residents less than seventeen (17) years of age. III

(9) The facility shall not care for more residents than the number for which the facility is licensed. II

(10) The facility's current license shall be readily visible in a public area within the facility. Notices provided to the facility by the Division of Aging granting exceptions to regulatory requirements shall be posted with the facility's license. III

(11) Regular daily visiting hours shall be established and posted. Relatives or guardians

and clergy, if requested by the resident or family, shall be allowed to see critically ill residents at any time unless the physician orders otherwise in writing. II/III

(12) A supervising physician shall be available to assist the facility in coordinating the overall program of medical care offered in the facility. II

(13) The facility shall develop policies and procedures applicable to its operation to insure the residents' health and safety and to meet the residents' needs. At a minimum, there shall be policies covering personnel practices, admission, discharge, payment, medical emergency treatment procedures, nursing practices, pharmaceutical services, social services, activities, dietary, housekeeping, infection control, disaster and accident prevention, residents' rights and handling residents' property. II/III

(14) A pharmacist currently licensed in Missouri shall assist in the development of written policies and procedures regarding pharmaceutical services in the facility. II/III

(15) All personnel shall be fully informed of the policies of the facility and of their duties. II/III

(16) All persons who have any contact with the residents in the facility shall not knowingly act or omit any duty in a manner which would materially and adversely affect the health, safety, welfare or property of a resident. I

(17) Effective August 28, 1997, each facility shall, not later than two (2) working days of the date an applicant for a position to have contact with residents is hired, request a criminal background check, as provided in sections 43.530, 43.540 and 610.120, RSMo. Each facility must maintain in its record documents verifying that the background checks were requested and the nature of the response received for each such request. The facility must ensure that any applicant who discloses prior to the check of his/her criminal records that he/she has been convicted of, plead guilty or nolo contendere to, or has been found guilty of any A or B felony violation of Chapter 565, 566 or 569, RSMo, or any violation of subsection 3 of section 198.070, RSMo, or of section 568.020, RSMo, will not be allowed to work in contact with patients or residents until and unless a check of the applicant's criminal record shows that no such conviction occurred. II/III

(18) The facility must develop and implement written policies and procedures which require that persons hired for any position which is to have contact with any patient or resident have been informed of their responsibility to disclose their prior criminal history to the facility as required by section 660.317.5, RSMo. The facility—

(A) Shall also develop and implement policies and procedures which ensure that the facility does not knowingly hire, after August 28, 1997, any person who has or may have contact with a patient or resident, who has been convicted of, plead guilty or *nolo contendere*

(B) May consider for employment, in positions which have contact with resident or patients, any person who has been granted a good cause waiver by the division in accordance with the provisions of section 660.317, RSMoSupp. 1999 and 13 CSR 30-82.060; and;

(C) Shall contact the division to confirm the validity of an applicant's good cause waiver prior to hiring the applicant. II/III

(19) No person who is listed on the employee disqualification list maintained by the division as required by section 198.070, RSMo shall work or volunteer in the facility in any capacity whether or not employed by the operator. II

(20) The facility shall develop and offer an in-service orientation and continuing educational program for the development and improvement of skills of all the facility's personnel, appropriate for their job function. Facilities shall begin providing orientation on the first day of employment for all personnel including licensed nurses and other professionals. At a minimum, this shall cover prevention and control of infection, facility policies and procedures including emergency protocol, job responsibilities and lines of authority, confidentiality of resident information and preservation of resident dignity including protection of the resident's privacy and instruction regarding the property rights of residents. Nursing assistants who have not successfully completed the classroom portion of the state-approved training program prior to employment shall not provide direct resident care until they have completed at least sixteen

(16)-hour, orientation module and at least twelve (12) hours of supervised practical orientation. This shall include, in addition to the topics covered in the general orientation for all personnel, special focus on facility protocols as well as practical instruction on the care of the elderly and disabled. This orientation shall be supervised by a licensed nurse who is on duty in the facility at the time orientation is provided. II/III

(21) Nursing assistants who have not successfully completed the state-approved training program shall complete a comprehensive orientation program within sixty (60) days of employment. This may be part of a nursing assistant training program taught by an approved instructor in the facility. It shall include, at a minimum, information on communicable disease, hand washing and infection control procedures, resident rights, emergency protocols, job responsibilities and lines of authority. II/III

(22) The facility must ensure there is a system of in-service training for nursing personnel which identifies training needs related to problems, needs, care of residents and infection control and is sufficient to ensure staff's continuing competency. II/III

(23) Facilities shall conduct at least annual in-service education for nursing personnel including training in restorative nursing. This training by a registered nurse or qualified therapist shall include: turning and positioning for the bedridden resident, range of motion (ROM) exercises, ambulation assistance, transfer procedures, bowel and bladder retraining and self-care activities of daily living. II/III

(24) A registered nurse shall be responsible for the planning and then assuring the implementation of the in-service education program for nursing personnel. II

(25) Facilities shall maintain records which indicate the subject of, and attendance at, all in-service sessions. III

(26) All authorized personnel shall have access to the legal name of each resident, name and telephone number of physician and next of kin or responsible party of each resident to contact in the event of emergency. II/III

(27) The facility must develop and implement policies and procedures which ensure employees are screened to identify communicable diseases and ensure that employees diagnosed with communicable diseases do not expose residents to such diseases. The facility's policies and procedures must comply with the Missouri Department of Health's regulations pertaining to communicable diseases, specifically 19 CSR 20-20.010 through 19 CSR20-20.100, as amended. II

(28) The administrator shall maintain on the premises an individual personnel record on each employee of the facility which shall include: the employee's name and address; Social Security number; date of birth; date of employment; experience and education; references, if available; the result of background checks required by section 660.317, RSMo; position in the facility; record that the employee was instructed on resident's rights; basic orientation received; and reason for termination. if applicable. Documentation shall be on file of all training received within the facility in addition to current copies of licenses, transcripts, certificates, or statements evidencing competency for the position held. Facilities shall retain personnel records for at least one (1) year following termination of employment. III

(29) Facilities shall maintain written documentation on the premises showing actual hours worked by each employee. III

(30) All persons who have or may have contact with residents shall at all times when on duty or delivering services wear an identification badge. The badge shall give their name, title and, if applicable the status of their license or certification as any kind of health care professional. This rule shall apply to all personnel who provide services to any resident directly or indirectly. III

(31) Employees other than nursing personnel shall be at least sixteen (16) years of age. II/III

(32) Nursing personnel shall be at least eighteen (18) years of age except that a person between the ages of seventeen (17) years of age and eighteen (18) years of age may provide direct resident care if he/she has successfully completed the state-approved nursing assistant course and has been certified with his/her name on the state nursing assistant register. He/she

must work under the direct supervision of a licensed nurse and will never be left responsible for a nursing unit. II/III

(33) All nurses employed by the facility shall be currently licensed in Missouri. II

(34) All facilities shall employ a director of nursing on a full-time basis who shall be responsible for the quality of patient care and supervision of personnel rendering patient care. II

(35) Licensed Nursing Requirements; Skilled Nursing Facility.

(A) The director of nursing shall be a registered nurse. II

(B) A registered nurse shall be on duty in the facility on the day shift. Either a licensed practical nurse (LPN) or a registered professional nurse (RN) shall be on duty in the facility on both the evening and night shifts. II

(C) A registered nurse shall be on call during the time when only an LPN is on duty. II

(36) Licensed Nursing Requirements; Intermediate Care Facilities.

(A) The director of nursing shall be either an RN or an LPN. II

(B) When the director of nursing is an LPN, an RN shall be employed as consultant a minimum of four (4) hours per week to provide consultation to the administrator and the director of nursing in matters relating to nursing care in the facility. II

(C) An LPN or RN shall be on duty and in the facility on the day shift. II

(D) An LPN or RN shall be on call twenty-four (24) hours a day, seven (7) days a week. I/II

(37) All facilities shall employ nursing personnel in sufficient numbers and with sufficient qualifications to provide nursing and related services which enable each resident to attain or maintain the highest practicable level of physical, mental and psychosocial well-being. Each facility shall have a licensed nurse in charge who is responsible for evaluating the needs of the residents on a daily and continuous basis to ensure there are sufficient, trained staff present to meet those needs. I/II

(38) Nursing personnel shall be on duty at all times on each resident-occupied floor. II

(39) Nursing assistants employed after January 1, 1980, shall have completed mandatory training as required by section 198.082, RSMo, or be enrolled in the course and functioning under the supervision of a state approved instructor of clinical supervisor as part of the one hundred (100) hours of on-the-job training. The person enrolled shall have successfully completed the course and become certified within one (1) year of employment with a licensed-only facility or within four (4) months of employment with a facility certified under Title XVIII or Title XIX if he or she is to remain employed in the facility as a nursing assistant. II

(40) Nursing personnel in any facility with more than twenty (20) residents shall not routinely perform non-nursing duties. II/III

(41) Nursing personnel in facilities with twenty (20) residents or less shall perform non-nursing duties only if acceptable infection control measures are maintained. II/III

(42) Each facility resident shall be under the medical supervision of a Missouri-licensed physician who has been informed of the facility's emergency medical procedures and is kept informed of treatments or medications prescribed by any other professional lawfully authorized to prescribe medications. I/II

(43) Facilities shall ensure that at the time the resident is admitted, the facility obtains from a physician the resident's primary diagnosis along with current medical findings and the written orders for the immediate care of the resident. II/III

(44) The facility shall ensure that the resident's private physician, the physician's designee, the facility's supervising physician or an alternate physician shall examine the resident at least annually, and shall examine the resident as often as necessary to ensure proper medical care. I/II

(45) For each medical examination, the physician must review the resident's care, including medications and treatments; write, sign and date progress notes; and sign and date all orders. The facility shall establish a policy requiring the physician to sign orders and to complete all other

documentation required if the physician does not visit the resident routinely. II/III

(46) No medication, treatment or diet shall be given without a written order from a person lawfully authorized to prescribe such and the order shall be followed. No restraint shall be applied except as provided in 13 CSR 30-88.010, Resident Rights. I/II

(47) There shall be a safe and effective system of medication distribution, administration, control and use. I/II

(48) Verbal and telephone orders for medication or treatment shall be given only to those individuals licensed or certified to accept orders. Orders shall be immediately reduced to writing and signed by that individual. If a telephone order is given to a certified medication technician, an initial dose of medication or treatment shall not be given until the order has been reviewed by telephone or in person by a licensed nurse or pharmacist. The review shall be documented by the reviewer cosigning the telephone order. II

(49) Medications shall be administered only by a licensed physician, a licensed nurse or a medication technician who has successfully completed the state-approved course for medication administration. II

(50) Injectable medication, other than insulin, shall be administered only by a licensed physician or a licensed nurse. Insulin injections may be administered by a certified medication technician who has successfully completed the state-approved course for insulin administration. II

(51) Self-administration of medication is permitted only if approved in writing by the resident's physician and it is in accordance with the facility's policy and procedures. II

(52) All medication errors and adverse reactions shall be reported immediately to the nursing supervisor and the resident's physician and, if there was a dispensing error, to the issuing pharmacist. II/III

(53) At least monthly a pharmacist or a registered nurse shall review the drug regimen of each resident. Irregularities shall be reported in writing to the resident's physician, the administrator, and the director of nurses. There must be written documentation which indicates how the reports were acted upon. II/III

(54) All prescription medications shall be supplied as individual prescriptions. All medications, including over-the-counter medications, shall be packaged and labeled in accordance with applicable professional pharmacy standards and state and federal drug laws and regulations. The *United States Pharmacopoeia* (USP) labeling shall include accessory and cautionary instructions as well as the expiration date, when applicable, and the name of the medication as specified in the physician's order. Over-the-counter medications for individual residents shall be labeled with at least the resident's name. II/III

(55) If the resident brings medications to the facility, they shall not be used unless the contents have been examined, identified and documented by a pharmacist or a physician. II/III

(56) Facilities shall store all external and internal medications at appropriate temperatures in a safe, clean place and in an orderly manner apart from foodstuffs and dangerous chemicals. A facility shall secure all medications, including those refrigerated, behind at least one (1) locked door or cabinet. Facilities shall store containers of discontinued medication separately from current medications. II/III

(57) Facilities shall store Schedule II medications, including those in the emergency drug supply, under double lock separately from non-controlled medication. Schedule II medications may be stored and handled with other non-controlled medication if the facility has a single unit dose drug distribution system in which the quantity stored is minimal and a missing dose can be readily detected. II

(58) Upon discharge or transfer, a resident may be given medications with a written order from the physician. Instructions for the use of those medications will be provided to the resident or the resident's designee. III

(59) All non-unit doses and all controlled

substances which have been discontinued must be destroyed on the premises within thirty (30) days. Outdated, contaminated, or deteriorated medications and non-unit dose medications of deceased residents shall be destroyed within thirty (30) days. Unit dose medications returnable to the pharmacy shall be returned within thirty (30) days. II/III

(60) Medications shall be destroyed in the facility by a pharmacist and a licensed nurse or by two (2) licensed nurses. III

(61) Facilities shall maintain records of medication destroyed in the facility. Records shall include: the resident's name; the date; the name, strength, and quantity of the medication; the prescription number; and the signatures of the participating parties. III

(62) The facility shall maintain records of medication released to the family or resident upon discharge or to the pharmacy. Records shall include: the resident's name; the date; the name, strength and quantity of the medication; the prescription number; and the signature of the persons releasing and receiving the medication. III

(63) The facility must establish a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation. The system must enable the facility to determine that drug records are in order and that an account of all controlled drugs is maintained and reconciled. II/III

(64) Facilities shall make available to all nursing staff up-to-date reference material on all medications in use in the facility. III

(65) The facility shall develop policies to identify any emergency stock supply of prescription medications to be kept in the facility for resident use only. This emergency drug supply must be checked at least monthly by a pharmacist to ensure its safety for use and compliance with facility policy. A facility shall have the emergency drug supply readily available to medical personnel and use of medications in the emergency drug supply shall assure accountability. III

(66) Each resident shall receive twenty-four (24)-hour protective oversight and supervision. For residents departing the premises on voluntary leave, the facility shall have, at a minimum, a procedure to inquire of the resident or resident's guardian of the resident's departure, of the resident's estimated length of absence from the facility, and of the resident's whereabouts while on voluntary leave. I/II

(67) Each resident shall receive personal attention and nursing care in accordance with his/her condition and consistent with current acceptable nursing practice. I/II

(68) Each resident shall be clean, dry and free of body and mouth odor that is offensive to others. I/II

(69) Taking into consideration the resident's preferences, residents shall be well-groomed and dressed appropriately for the time of day, the environment and any identified medical conditions. II/III

(70) Residents who are physically or mentally incapable, or both, of changing their own positions shall have their positions changed at least every two (2) hours and shall be provided supportive devices to maintain good body alignment. I/II

(71) The facility must provide each resident the opportunity to access sufficient fluids to maintain proper hydration in accordance with the resident's medical condition and goals of treatment as documented in the medical record. I/II

(72) All residents who require assistance at mealtimes, whether it is preparation of the food items or actual feeding, shall be provided the assistance upon delivery of the tray. Facilities shall provide dining room supervision during meals. II/III

(73) Facilities shall provide each resident, according to his/her needs, with restorative nursing to encourage independence, activity and self-help to maintain strength and mobility. Each resident shall be out of bed as desired unless medically contraindicated. II

(74) Each resident shall have skin care including the application of oil, lotion and cream as needed to prevent dryness and scaling of skin. II/III

(75) Facilities shall keep residents free from avoidable pressure sores, taking measures toward prevention. If sores exist, staff shall give adequate treatment. I/II

(76) Facility staff shall check residents requiring restraints every thirty (30) minutes and exercise the residents every two (2) hours. II/III

(77) Facilities shall not use locked restraints. I

(78) Residents shall be cared for by using acceptable infection control procedures to prevent the spread of infection. The facility shall make a report to the division within seven (7) days if a resident is diagnosed as having a communicable disease, as determined by the Missouri Department of Health and listed in the Code of State Regulations pertaining to communicable diseases, specifically 19 CSR 20-20.020, as amended. I/II

(79) In the event of accident, injury, or significant change in the resident's condition, facility staff shall notify the resident's physician in accordance with the facility's emergency treatment policies which have been approved by the supervising physician. I/II

(80) In the event of accident, injury or significant change in the resident's conditions, facility staff shall immediately notify the person designated in the resident's record as the designee or responsible party. III

(81) Staff shall inform the administrator of accidents, injuries and unusual occurrences which adversely affect, or could adversely affect the resident. The facility shall develop and implement responsive plans of action. III

(82) Facilities shall ensure that each resident is provided individual personal care items necessary for good grooming. Items shall be stored and maintained in a clean manner within the resident's room. III

(83) Facilities shall provide equipment and nursing supplies in sufficient number to meet the needs of the residents. II/III

(84) Facilities shall keep all utensils and equipment in good condition, effectively sanitized, sterilized, or both, and stored to prevent contamination. II/III

(85) Staff shall ensure that bedpans, commodes, and urinals are covered after use, emptied promptly and thoroughly cleaned after use. II/III

(86) Facilities shall provide and use a sufficient supply of clean bed linen, including sheets, pillow cases, blankets, and mattress pads to assure that resident beds are kept clean, neat, dry and odor free. II/III

(87) Staff shall use moisture proof covers as necessary to keep mattresses and pillows clean, dry and odor free. II/III

(88) Facilities shall provide each resident with fresh bath towels, hand towels and washcloths as needed for individual usage. II/III

(89) In addition to rehabilitative or restorative nursing, all facilities shall provide or make arrangements for providing rehabilitation services to all residents according to their needs. If a resident needs rehabilitation services, a qualified therapist shall perform an evaluation on written order of the resident's physician.

(90) Facilities shall ensure that rehabilitation services are provided by or under the on-site supervision of a qualified therapist or a qualified therapy assistant who works under the general supervision of a qualified therapist. I/II

(91) Staff shall include the following in documentation of rehabilitation services: physician's written approval for proposed plan of care; progress notes at least every thirty (30) days by the therapist; daily record of the procedure(s) performed; summary of therapy when rehabilitation has been reached and, if applicable, recommendations for maintenance procedures by restorative nursing. III

(92) The facility shall designate a staff member to be responsible for the facility's social services program. The designated staff person shall be capable of identifying social and emotional needs, knowledgeable of methods or resources, or a combination of these, to use to meet them and services shall be provided to residents as needed. II/III

(93) The facility shall designate an employee to be responsible for the activity program. The designated person shall be capable of identifying

activity needs of residents, designing and implementing programs to maintain or increase, or both, the resident's capability in activities of daily living. Facilities shall provide activity programs on a regular basis. Each resident shall have a planned activity program which includes individualized activities, group activities and activities outside the facility as appropriate to his/her needs and interests. II/III

(94) The facility shall provide and use adequate space and equipment within the facility for the identified activity needs of residents. II/III

(95) The facility shall establish and maintain a program for informing all residents in advance of available activities, activity location and time. III

(96) Facility staff shall include the following general information in admission records: resident's name; prior address; age (birth date); sex; marital status; Social Security number, Medicare and Medicaid numbers; date of admission; name, address and telephone number of responsible party; name, address and telephone number of attending physician; height and weight on admission; inventory of resident's personal possessions upon admission; and names of preferred dentist, pharmacist and funeral director. II/III

(97) Facility staff shall include physician entries in the medical record with the following information: admission diagnosis, admission physical and findings of subsequent examinations; progress notes; orders for all medications and treatment; orders for extent of activity; orders for restraints including type and reason for restraint; orders for diet; and discharge diagnosis or cause of death. II/III

(98) Residents admitted to a facility on referral by the Department of Mental Health shall have an individualized treatment plan or individualized habilitation plan on file which is updated annually. III

(99) Facilities shall ensure that the clinical record contains sufficient information to

(A) Identify the resident;

(B) Reflect the initial and ongoing assessments and interventions by each discipline involved in the care and treatment of the resident; and

(C) Identify the discharge or transfer destination. II/III

(100) Facilities shall ensure that the resident's clinical record must contain progress notes that include, but are not limited to:

(A) Response to care and treatment;

(B) Change(s) in physical, mental and psychosocial condition;

(C) Reasons for changes in treatment; and

(D) Reasons for transfer or discharge. II/III

(101) The facility must safeguard clinical record information against loss, destruction, or un-authorized use. III

(102) The facility must keep all information confidential that is contained in the resident's records regardless of the form or storage method of the records, including video-, audio- or computer-stored information. III

(103) The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices. These records shall be complete, accurately documented, readily accessible on each nursing unit and systematically organized. II/III

(104) Facilities must retain clinical records for the period of time required by state law or five (5) years from the date of discharge when there is no requirement in state law. III

(105) Facilities shall retain all financial records related to the facility operation for seven (7) years from the end of the facility's fiscal year. III

(106) In the event the resident is transferred from the facility, the resident shall be accompanied by a copy of the medical history, transfer forms which include the physical exam report, nursing summary and report of orders physicians prescribed. II/III

AUTHORITY: sections 198.006, RSMo Supp.2003 and 198.079, RSMo 2000..

**Original authority 1979.*

CONSTRUCTION STANDARDS AND PHYSICAL PLANT REQUIREMENTS FOR MEDICATION ROOMS AND OXYGEN STORAGE.

19 CSR 30-85.012 Construction Standards for New Intermediate Care and Skilled Nursing Facilities and Additions to and Major Remodeling of Intermediate Care and Skilled Nursing Facilities (partial)

> (48) Facilities shall provide a medicine preparation room next to each nurses' station that has at least sixty (60) square feet of useable floor space. Facilities shall provide a special locked medication cabinet for storage of the Class II medications inside the locked medication cabinet. If the outer cabinets are not locked, the facility must provide a closer and hardware that cannot be left unlocked on the door to the medicine room. A facility is also required to have the following in the medicine room: a work counter, handwashing sink, under cabinet storage, a medicine refrigerator, adequate lighting, and provisions for proper temperature control. II/III

19 CSR 30-85.032 Physical Plant Requirements for New and Existing Intermediate Care and Skilled Nursing Facilities (partial)

> (14) Oxygen cylinders for medical use shall be labeled Oxygen - United States Pharmacopoeia (USP). Existing facilities with plans approved on or before December 31, 1998, shall have oxygen systems, oxygen piping, outlets, manifold rooms and storage rooms installed in accordance with the requirements of the NFPA 99, *Health Care Facilities*, as referenced in the 1985 *Life Safety Code*. Facilities with plans approved on or after January 1, 1999, shall install oxygen systems in compliance with the 1996 NFPA 99 and the 1997 *Life Safety Code*. I/II

> (26) The facility shall provide either a nursing station or a nurses' work area on each floor of a multi-story facility. This area shall have chart storage space on current residents. Facilities licensed or with plans approved on or after July 1, 1965, shall have a nurses' station for every sixty (60) beds. Handwashing facilities at or near the nurses' station shall be available for physicians, nurses and other personnel, attending residents. II/III

EXCERPTS FROM MISSOURI PHARMACY LAW

Missouri pharmacy law is found in Chapter 338 of the Revised Statutes of Missouri. The practice of pharmacy includes participating in drug selection and drug use review, dispensing drugs pursuant to prescription orders, and consulting with patients and health care practitioners about safe and effective use of drugs. Only pharmacists and pharmacy technicians under the supervision of a pharmacist may package, label, and dispense prescriptions to Long Term Care Facility (LTCF) residents from a pharmacy.

Prescribers, such as physicians and dentists, are allowed under pharmacy law to dispense to their patients. Although not specifically provided for in pharmacy law, nurses and physician assistants may dispense medications under the authority of a physician in certain settings as allowed by state law.

Pharmacies that provide services to LTCFs must have specific LTCF policies and procedures that are in compliance with regulations for receiving new prescriptions; packaging, labeling, and dispensing prescriptions; and accepting returned prescriptions.

Pharmacies may receive orders from LTCFs as prescriptions if the order is initiated by a prescriber and entered into the resident's medical record by the prescriber or qualified personnel. Only a pharmacist can change the package or label of a dispensed prescription.

Prescriptions that are returned to the pharmacy cannot be reused unless there is assurance that they have been properly stored, were originally dispensed by that pharmacy to the LTCF, and remain in the original tamper-evident or unit of use packaging.

Pharmacies may operate automated dispensing systems located physically in LTCFs. A pharmacist must review and approve a new medication order before the medication is released from the system storage cabinet. The pharmacy is responsible for stocking, security, record keeping, and procedures for use of the system by facility staff.

EXCERPTS FROM THE MISSOURI NURSE PRACTICE ACT

NURSING 335.016: (7) "Practical nursing" is the performance for compensation of selected acts for the promotion of health and the care of persons who are ill, injured, or experiencing alterations in normal health processes. Such performance requires substantial specialized skill, judgment, and knowledge. All such nursing care shall be given under the direction of a person licensed in this state to prescribe medications and treatments or under the direction of a registered professional nurse.

(8) "Professional nursing" is the performance for compensation of any act which requires substantial specialized education, judgment, and skill based on knowledge and application of principles derived from the biological, physical, social and nursing sciences, including, but not limited to:

> (c) The administration of medications and treatments as prescribed by a person licensed in this state to prescribe such medications and treatments;

335.081. Exempted practices and practitioners - So long as the person involved does not represent or hold himself out as a nurse licensed to practice in this state, no provision of sections 335.011 to 335.096 shall be construed as prohibiting:
(2) The services rendered by technicians, nurses' aides or their equivalent trained and employed in public or private hospitals and licensed long-term care facilities except the services rendered in licensed long-term care facilities shall be limited to administering medication, excluding injectables other than insulin.

Interpretation - Under 335.016 only a nurse may administer medications. However, 335.081 (2) makes an exception and allows trained aides (CMT's) to administer medications in licensed long- term care facilities excluding injectables other than insulin. However, in order to give insulin, special training is required.

SCHEDULES OF CONTROLLED SUBSTANCES

Controlled substances are listed in one of five schedules. Schedule I substances have no accepted medical use in the U.S. and have high abuse potential. Schedule II drugs have high abuse potential with severe psychic or physical dependence, liability, and in general are substances that have therapeutic utility. Schedules III-V includes drugs with decreasing levels of abuse potential. Some substances are in more than one Schedule based on product content. There are some differences between federal and state schedules of controlled substances. Representative examples are listed below but the list is not all-inclusive.

SCHEDULE I

DMA
gamma hydroxybutyric acid (GHB)
heroin
LSD
marijuana
MDMA (Ecstasy)
mescaline
peyote

SCHEDULE II

amobarbital (Amytal)
butyl nitrite (Rush)
cocaine
codeine
dextroamphetamine (Dexedrine, Adderal)
diprenorphine (M 50-50)
dronabinol (Marinol)
etorphine (M 99)
fentanyl (Sublimaze, Duragesic, Actiq)
hydromorphone (Dilaudid)
levomethadyl (Orlaam)
meperidine (Demerol)
methadone (Dolophine)
methamphetamine (Desoxyn)
methylphenidate (Ritalin)
morphine (Roxanol, MS Contin, MSIR)
opium
oxycodone (Percocet, Tylox, OxyContin)
pentobarbital (Nembutal)
phencyclidine (PCP)
secobarbital (Seconal)
sufentanil (Sufenta)

SCHEDULE III

benzphetamine (Didrex)
buprenorphine (Buprenex)
butalbital (Fiorinal)
codeine (Tylenol or Fiorinal w/codeine)
dihydrocodeine (Synalgos DC)
fluoxymesterone (Halotestin)
gamma hydroxybutyric acid dose form
hydrocodone (Tussionex, Vicodin, Lortab)
ketamine (Ketalar, Vetalar, Ketaset)
methyltestosterone (Android, Oreton)
nandrolone (Deca-Durabolin)
opium (paregoric)
pentobarbital (Beuthanasia-D Special)
phendimetrazine (Prelu-2)
stanazolol (Winstrol)
testosterone (Android-T, Delatestryl)
thiopental (Pentothal)
tiletamine/zolazepam (Telazol)

SCHEDULE IV

alprazolam (Xanax)
butorphanol (Stadol, Torbugesic)
chloral hydrate (Noctec, Somnos)
chloradiazepoxide (Librium)
clonazepam (Klonopin)
clorazepate (Tranxene)
codeine (Robitussin AC, Phenergan w/ Codeine)
dextropropoxyphene (Darvon, Darvocet)
diazepam (Valium)
dichloralphenazone (Midrin)
difenoxin (Motofen)
diethylpropion (Tenuate)
ephedrine
ethchlorvynol (Placidyl)
flurazepam (Dalmane)
lorazepam (Ativan)
mazindol (Sanorex)
mephobarbital (Mebaral)
meprobamate (Equanil)
methohexital (Brevital)
midazolam (Versed)
modafinil (Provigil)
oxazepam (Serax)
paraldehyde
pemoline (Cylert)
pentazocine (Talwin)
phenobarbital
phentermine (Ionamin, Fastin)
sibutramine (Meridia)
temazepam (Restoril)
triazolam (Halcion)
zaleplon (Sonata)
zolpidem (Ambien)

SCHEDULE V

diphenoxylate (Lomotil)

EXEMPTED or EXCLUDED SUBSTANCES

butalbital (Fioricet)
l-deoxyephedrine (Vicks inhaler)
chlordiazepoxide (Librax)
propylhexedrine (Benzedrex inhaler)

LESSON PLAN: 3

COURSE TITLE: MEDICATION TECHNICIAN

UNIT: I INTRODUCTION

EVALUATION ITEMS:

Match definitions on the left with terms on the right.

____ 1. Any medication that is used for discipline or convenience and is not required to treat. medical symptoms.

____ 2. Immediate responsibility by a resident for the storage and administration of medication for oneself while the facility retains ultimate control of the medication.

____ 3. Any structure or structures that are in close proximity one to the other and which are located on a single piece of property

____ 4. Responsibility by the facility for all facets of control of medication, including but not limited to acquisition, storage, security, and administration of medication.

____ 5. The act of actually taking or applying medication to oneself

____ 6. A nursing assistant who has completed a course in medication administration approved by the Division of Health & Senior Services.

a. Certified Medication Technician

b. Chemical restraint

c. Control of medication

d. Premises

e. Self administration of medication

f. Self control of medication

7. What are two state regulations related to drug administration?

   a.

   b.

Circle the letter of the best answer.

8. How soon should verbal orders be put in writing?

   a. Within 24 hours.
   b. The next day.
   c. Immediately.
   d. By the next shift.

9. The medication technician does not give the initial dose or treatment on a phone order until the order is reviewed by ____ .

   a. no one
   b. another CMT
   c. the administrator
   d. licensed nurse or pharmacist

10. Medications brought to the facility by the resident ____ .

   a. can be used right away
   b. cannot be used at all
   c. can be used after 7 days
   d. cannot be used unless identified by a pharmacist or physician

11. What information must be included on medication records?

   a.

   b.

   c.

   d.

   e.

   f.

   g.

   h.

12. What are two federal regulations related to drug administration?

   a.

   b.