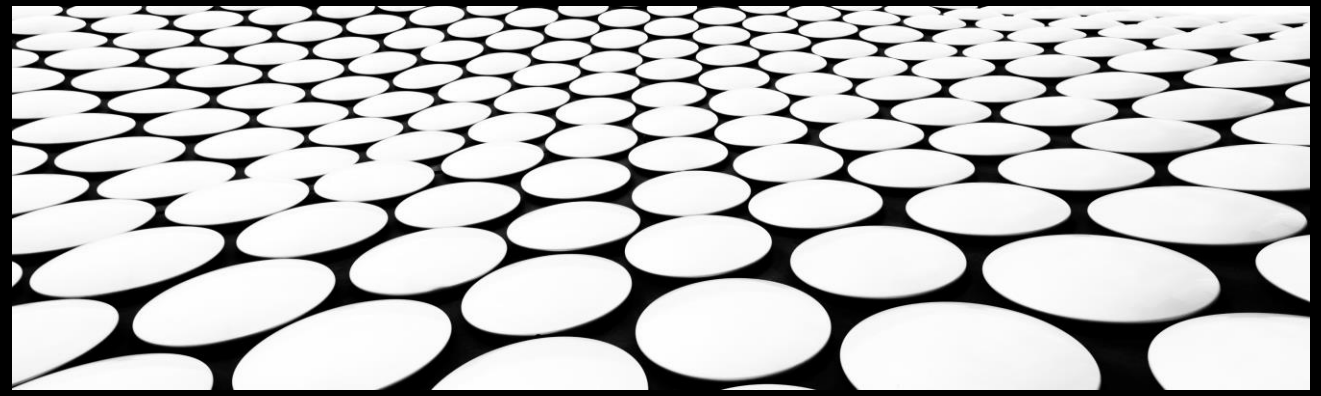
MEDICATION ADMINISTRATION COMPLIANCE

This session will focus on common medication administration citations and incidents related to medication administration. A sharing of pitfalls that agencies need to avoid when it comes to medication administration and how to effectively maintain compliance.



PRESENTED BY: DEB MALOY, RN, CDDN, TARRYTOWN EXPOCARE PHARMACY, DIRECTOR OF SALES AND EDUCATION, DDNA PRESIDENT-ELECT

VESTED INTEREST: EMPLOYED BY TARRYTOWN EXPOCARE PHARMACY

MEDICATIONS PLAY AN IMPORTANT ROLE IN MANAGING CHRONIC CONDITIONS AS WELL AS ACUTE CONDITIONS

PEOPLE WITH DOWN SYNDROME IN 1983 MEAN AGE OF 25 YEARS.
TODAY, IT IS ALMOST 60 YEARS

AS ONE AGES, ONE EXPERIENCES MORE MEDICAL CHANGES-HYPERTENSION, DIABETES, OSTEOARTHRITIS, AND ASTHMA, FOR EXAMPLE

www.nationwidechildrens.org/family-resources-education/700childrens/2021/07/down-syndrome-life-expectancy

IMPORTANT TO NOTE THAT SOME HEALTH CONDITIONS SUCH AS ASTHMA, GASTROINTESTINAL SYMPTOMS, ECZEMA AND SKIN ALLERGIES, AND MIGRAINES HAVE BEEN FOUND TO BE MORE COMMON IN CHILDREN WITH DEVELOPMENTAL DISABILITIES.

Facts%20About%20Developmental%20Disabilities%20_%20CDC.html

DD CONDITION-RELATED ILLNESS:

- MOBILITY-RELATED PROBLEMS, SEIZURES, SENSORY IMPAIRMENT
- GASTROINTESTINAL, ENDOCRINE (THYROID), DEMENTIA

- AND FOR SUCH CONDITIONS, MEDICATIONS PLAY AN IMPORTANT ROLE IN CONTROLLING THESE CHRONIC ILLNESSES, AS WELL

IN TURN MORE MEDICAL CHANGES-
MORE MEDICATIONS-
MORE POTENTIAL FOR DRUG-2-DRUG INTERACTIONS-

(PHARMACY ASSISTANCE TO AID IN MONITORING AND IMPORTANCE OF ONE PHARMACY IN USE)

AND MORE POTENTIAL SIDE EFFECTS

Facts About Developmental Disabilities | CDC

Medication Related Problems In General

UMich doc S Erickson Collee of Pharmacy-

R Ghandi TK, Weingart Sn Boris J, et al. Adverse Drug Events in Ambulatory Care

New England Journal of Medicine 2003;348:1556-1564

UNDER-TREATMENT

OVER-TREATMENT

POOR ADHERENCE-UP TO 50% OF PEOPLE PRESCRIBED MEDICATION DO NOT CONTINUE TO TAKE IT OR WILL TAKE LESS THAN PRESCRIBED

INAPPROPRIATE DRUG SELECTION (PRESCRIBER, PATIENT)

ADVERSE EVENTS OCCUR IN UP TO 25% OF PEOPLE IN THE COMMUNITY

Safe Use of Medications

Overwhelmingly, medications are safe for use

- Problems occur due to
  - Medication side effects, unintended effects
  - Administration errors

Approximately 1.3 million people injured annually in U.S. by medication errors

National Coordinating Council for Medication Error Reporting and Prevention

ALEX'S STORY

WHAT IS A MEDICATION ERROR?
THE COUNCIL DEFINES A "MEDICATION ERROR" AS FOLLOWS:

A MEDICATION ERROR IS ***ANY PREVENTABLE EVENT*** THAT MAY CAUSE OR ***LEAD TO INAPPROPRIATE MEDICATION USE OR PATIENT HARM*** WHILE THE MEDICATION IS ***IN THE CONTROL OF THE HEALTH CARE PROFESSIONAL***, PATIENT OR CONSUMER. SUCH EVENTS MAY BE RELATED TO PROFESSIONAL PRACTICE, HEALTH CARE PRODUCTS, PROCEDURES, AND SYSTEMS, INCLUDING PRESCRIBING, ORDER COMMUNICATION, PRODUCT LABELING, PACKAGING, AND NOMENCLATURE, COMPOUNDING, DISPENSING, DISTRIBUTION, ***ADMINISTRATION, EDUCATION, MONITORING AND USE."***

National Coordinating Council for Medication Error Reporting and Prevention

OHIO MUI'S

Most medication errors are reported and investigated as unusual incidents by the provider.

Only medication errors raising to the level of neglect, would be filed and investigated as MUIs.

In cases when a person is also hospitalized, has a medical emergency, or dies, those MUI categories would be investigated along with the neglect allegation.

(DODD MUI Unit Data 10/2021)

OHIO MUI'S

NEGLECT:

When there is a duty to do so, failing to provide an individual with a medical care, personal care, or other support that consequently results in serious injury or places an individual or another person at risk of serious injury.

Serious injury means an injury that results in treatment by a physician, physician assistant, or nurse practitioner.

(DODD MUI Definitions

OHIO MUI'S

Each year, there are around 1,000-1,500 neglect allegation MUIs investigated.

In 2020, there were 994 neglect MUI's:

41% (407) MUIs were investigated for lack of treatment (including medication errors, not providing timely medical care) and 59% were due to supervision concerns.

(What is a med error, defined by NCCERP: ***"administration, education, monitoring and use"***

NOTE: When Delegation (when a nurse must be involved) is not required then the agency bears the primary responsibility of medication administration oversight.

OHIO MUI'S

MUIs of Neglect / Treatment Examples

-***Person not giving medication or given another person's medications***

-Lack of medical attention

-Staff fails to administer CPR

-Not calling 911

-Failure to follow Dr's orders

REMINDER:

WHAT IS A MEDICATION ERROR?
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National Coordinating Council for Medication Error Reporting and Prevention

OHIO MUI'S

While these are actual statistics in Ohio, these same issues can apply anywhere.

Most Common Medication Errors Resulting in Neglect MUIs:

1. Medications are prepared in advance and another person takes them resulting in ER observation or hospitalization.

Medication Error Neglect MUI Examples: (Real Cases, names have been changed)

A DSP prepared Daniel's medications in a medication cup and laid them on the desk, waiting for him to come get his medications. In the meantime, Henry entered the room and took his peer's medications and ingested them.

Poison control was contacted and advised that Henry would be sleepy and to monitor him. Approximately 10 minutes later, Henry was observed to be drooling and was taken to the emergency room. At the hospital, he was given Narcan. Henry was subsequently hospitalized for 2 days and released home.

Medication Error Neglect MUI Examples: (Real Cases, names have been changed)

Staff prepared Jamal's medication along with another individual's medication and placed them in a medication cup on the dining table. While the staff was doing dishes, Jamal stood in the dining area and took the medication cup with another individual's medication(s). That staff left and another arrived. The relieving staff was unaware of the medication error, but later noticed that Jamal was not breathing normally and could not wake him. 911-EMS was called, and Jamal was transported to Hospital where he was later admitted. Jamal remained in the hospital for a total of 6 days and then was released home.

OHIO MUI'S

Most Common Medication Errors Resulting in Neglect MUIs:

2. Staff inadvertently give someone another persons medication that makes them ill

Medication Error Neglect MUI Examples: (Real Cases, names have been changed)

Staff inadvertently administered Ahmed the wrong medications. Staff gave him his roommates medications instead, which included Chlorpromazine, Divalproex, Clonazepam, Propranolol, and Risperidone. His physician was notified and asked staff to take his vitals. They reported his blood pressure and heart rate was low. The doctor ordered that Ahmed be taken to hospital. He was admitted and given an IV to clear the medication out of his system. He went home after 3 days.

OHIO MUI'S

Most Common Medication Errors Resulting in Neglect MUIs:

3. Medication is not refilled, and no one takes responsibility for calling or obtaining the medication sometimes resulting in weeks or months without that medication being administered and the person has an adverse effect.

Easy to think, this won't happen on my watch, but it can, remember Alex.

Medication Error Neglect MUI Examples: (Real Cases, names have been changed)

The program supervisor took Katie to a medical appointment several hours away. She was not given her morning medications, which included seizure medication. Katie had a seizure in the vehicle while on the way home late that afternoon. She was taken to the hospital. While waiting for test results, Katie had another seizure. Katie was taken to another hospital and while in the ambulance being transferred had a 3rd breakthrough seizure. She was hospitalized for two days and then discharged.

Causes and Contributing Factors to Medication Error Neglect MUIs:

(Ohio)

-Didn't Follow 6 Rights of Medication Administration (I.M.D.R.T.D.)

*Right Individual
*Right Medication
*Right Dose
*Right Route
*Right Time/Date
*Right Documentation

(South Carolina)

8 Rights of Medication Administration

*Right Individual
*Right Medication
*Right Dose
*Right Route
*Right Time/Date
*Right Documentation
*Right Texture
*Right Position

Causes and Contributing Factors to Medication Error Neglect MUIs:

-

Using medication cups to prepare medications ***in advance*** instead of taking medication from pill bottle or package (and administering at that time to one person).

Provider does not have a process of who will monitor to ensure medications are available and refilled when needed.

Leaving medications out where another person could pick them up and ingest it.

*NEVER leave medication unattended (in medicine cup or packaged meds)

Causes and Contributing Factors to Medication Error Neglect MUIs:

Change in routine (appointment, holiday or trip) and medications are not packed or administered.

DSP was not trained to work with the person and is unaware of medication needs

MEDICATION ADMINISTRATION PITFALLS

- WHAT'S REALITY?
  - BUSY SCHEDULES
  - LACK OF STAFFING
  - SHORTCUTS
  - INTERRUPTIONS
  - BEHAVIORAL ISSUES
  - MEDICAL ISSUES
  - STAFF BAGGAGE
    - MENTAL HEALTH/PERSONAL ISSUES/STRESSED/OVERTIME
  - FAILURE TO DOCUMENT
  - NO CONTROL COUNT ACCOUNTABILITY
  - LACK OF COMMUNICATION
  - OVERLAP OF STAFFING OR MULTIPLE STAFF PASSING MEDS

MEDICATION ADMINISTRATION PITFALLS

- "IT'S JUST A JOB"
- DISTRACTED
- LEARN BAD HABITS
- MORALE OF AGENCY/SUPERVISOR
- LACK OF SUPERVISOR SUPPORT
- LACK OF TIME
- APPOINTMENT PREPARATION
- MULTIPLE REQUESTS
- PREP FOR THE DAY-GET OUT THE DOOR, DAY PROGRAM, WORK, MEDICAL ISSUES, BEHAVIORAL ISSUES, ETC.
- LACK OR INADEQUATE POLICY/PROCEDURE-OR STAFF NOT TRAINED ON/ACCESS TO REFER TO
- LACK OF OVERSIGHT OF MEDICATION ADMINISTRATION
- MULTIPLE RESPONSIBILITIES

MEDICATION ADMINISTRATION EXPECTATIONS

- EXPECTATIONS OF MEDICATION ADMINISTRATION
  - 100% COMPLIANCE:
    - IS THIS REALISTIC? NO ONE IS PERFECT!
    - SOMETIMES, STAFF ARE JUST DOING THEIR BEST!

    - Ensure ability of staff to report/self-report. BEST to head it off before becomes an issue-a potential fatality

- OVERSIGHT-TAKE THE TIME NOW OR TAKE MORE TIME LATER WITH POTENTIALLY WORSE OUTCOMES INCLUDNG DEATH

- LOOK AT WHAT CAN BE DONE TO ASSIST

MEDICATION ADMINISTRATION EXPECTATIONS

HOW DO WE GET WHERE WE NEED TO BE?

KNOW LAW AND RULE SUPPORTING MEDICATION ADMINISTRATION

- ATTEND YOUR STATES RN TRAIN THE TRAINER COURSE, IF APPLICABLE, KNOW YOUR RESPONSIBILITY AND THE NURSES

POLICY AND PROCEDURE FOR MEDICATION ADMINISTRATION

- "ADOPT" THE MEDICATION ADMINISTRATION CURRICULUM FOR PnP AND SPECIFY WHERE IT NOTES "OR PER AGENCY POLICY"

INCLUDE QA PnP

INCLUDE OVERSIGHT RESPONSBILITIES-ASSIGNMENTS OF WHO

MEDICATION ADMINISTRATION EXPECTATIONS

HOW DO WE GET WHERE WE NEED TO BE?

INCLUDE ADMINISTERING MEDICATION BY WHOM (WHICH SHIFT ADMINISTERS MEDS IF MED PASS TIME IS AT A SHIFT CHANGE, ONE STAFF DESIGNATED-AVOID MULTIPLE PEOPLE PASSING MEDS AND IF SO

- BE VERY SPECIFIC ON WHO IS PASSING WHAT/WHEN
- AVOID HAVNG MULTIPLE STAFF PASS MEDS ON THE SAME SHIFT

MEDICATION ADMINISTRATION EXPECTATIONS

HOW DO WE GET WHERE WE NEED TO BE?

AGENCY OVERSIGHT ULTMATE RESPONSIBILITY

ENSURE MED CERTIFICATIONS/TRAINING TO ADMINISTER

ENSURE ABILITY TO ADMINISTER MEDICATIONS/TREATMENTS AND PERFORM HEALTH RELATED ACTIVITIES

- AWARE OF CLASSROOM VERSUS MED PASS TO LIVE PERSON
- PROCESS TO ENSURE ABILITY, DO NOT ASSUME CAN DO

RELEVANT SKILLS

MEDICATION ADMINISTRATION EXPECTATIONS

HOW DO WE GET WHERE WE NEED TO BE?

AGENCY SUPPORT

- STAFF WORKING ON A WEEKEND FOR FIRST SHIFT - ALONE
- ABILITY TO CONTACT SOMEONE (AND ACTUALLY REACH SOMEONE)

KNOW IF DELEGATION IS REQUIRED AND KNOW EXPECTATIONS OF THE DELEGATING NURSE

- ABILITY OF STAFF TO CONTACT DIRECTLY WHEN TASK PERFORMED

MEDICATION ADMINISTRATION EXPECTATIONS

HOW DO WE GET WHERE WE NEED TO BE?

FOLLOWING CURRICULUM GUIDELINES

- 6/8 RIGHTS OF MEDICATION ADMINISTRATION
  - I.M.D.R.T.D.
    - ENSURES GIVEN TO THE RIGHT PERSON, THE RIGHT MEDICATIONS, RIGHT DOSE, RIGHT ROUTE, AND AT THE RIGHT TIME AS WELL AS IN THE RIGHT TEXTURE AND IN THE RIGHT POSITION
- 3 MAR CHECK-LABEL TO MAR

MEDICATION ADMINISTRATION EXPECTATIONS

HOW DO WE GET WHERE WE NEED TO BE?

- DOCUMENTATION
  - ACCURATE AND TIMELY
  - DOT SYSTEM-ENSURE ALL MEDS ARE ADMINISTERED
  - SYSTEM TO ENSURE ADMINISTRATION-QA/SUPERVISOR OVERSIGHT

CONSEQUENCES WHEN DOCUMENTATION DOES NOT HAPPEN

ENSURE CHECK IF ADMINISTERED TO AVOID DUPLICATION

DATE/INIITAL BLISTER PACK (NOT LEGAL DOC) BUT MEANS TO ASSIST IN ADMINISTRATION VERIFICATION-CONTACT STAFF TO CONFIRM

INITIAL AND CIRCLE ANY "DIVERSION" TO ADMINISTRATION/NOTE ON BACK OF MAR

MEDICATION ADMINISTRATION EXPECTATIONS

HOW DO WE GET WHERE WE NEED TO BE?

- DRUG FACT INFORMATION
- TRAINING ON EACH INDIVIDUAL AND KNOW MED PASS TIMES IN THE HOME
  - CERTIFICATION—IST—ADMINISTER MEDICATIONS
- FOLLOW CURRICULUM
  - HELD ACCOUNTABLE TO
- SET UP MEDS FOR ONE PERSON AT A TIME AND ALWAYS MAINTAIN IN STAFF'S POSSESSION-DO NOT PREPARE IN ADVANCE, PREPARE AND ADMINISTER AND THEN DOCUMENT

MEDICATION EXPECTATIONS

Encourage the reporting of medication errors to appropriate personnel/authorities

These medication error reports may be used to identify significant trends or patterns that can lead to improved quality and safety of health care, and to teach others how to prevent similar errors.

-Health and Welfare Alert

-Monitor Trends and Patterns

Empower staff to report and consequences of not reporting (versus when staff do report – sense is negative)

MEDICATION ADMINISTRATION EXPECTATIONS

ACCESS TO NECESSARY INFORMATION

ALL MEDICATIONS ON LIST FOR APPONTMENTS

- (ROUTINE, AS NEEDED- INCLUDE ALL MEDS PRESCRIBED BY ALL PRESCRIBERS, CURRENT LIST. (Appointment form).

MEDICATION ADMINISTRATION EXPECTATIONS

Document any issues-have a format for staff to report anything out of the ordinary (must know the person). TRAINING, TRAINING, TRAINING (and document)

- WHEN A MEDICAL ISSUE OCCURS - ENSURE OVERSIGHT, CONTACT PCP/ER, AND COMMUNICATION TO ONCOMING SHIFT, REPORT TO SUPERVISOR, AT MINIMUM-CAN TAKE PULSE AND RESPIRATION EVEN IF NOT DONE ROUTINELY (INLCUDE BASICS – SKILL CHECK.

Reference to a "cheat" sheet, "get to know" form for staff to review, or someone to call and ASK.

Never assume someone else will report.

MEDICATION ADMINISTRATION EXPECTATIONS

- Process for medication oversight
  - Who will monitor
  - What are they monitoring
  - When is to be monitored
  - How is it to be monitored
  - Understand why it is being performed

Medication Availability-how often delivered

How are medications processed for administration (single dose versus multi-dose packaging / weekly or monthly delivery)

Medication Refills-Need to Order or does your pharmacy fill them automatically?

MEDICATION FIXES

When a medication error occurs, evaluate possible causes in order to improve the facility's system for medication management and to prevent future errors.

Get to the Root of the problem.

Root Cause Analysis:

A occurred because of B, B occurred because of C, etc..

In Ohio the role of the QARN is as a consultant and uses the Root Cause Analysis to assist in determining source of medication errors.

MEDICATION FIXES

Root Cause Analysis:

Be open and honest as to the “why” a diversion occurred:

it may be a staffing issue (insufficient staff at med pass time, environmental, personnel issue (incompetent) too many asks at that time-evaluate med pass times, move daily meds to an afternoon/evening dose if feasible.

PROMOTE MEDICATION EXPECTATIONS

Promote a culture in which it is acceptable, and strongly encouraged, for staff to question prescribers when there are any questions or disagreements about orders. Questions about ANY, but especially about verbal orders should be resolved before the preparation, dispensing, or administration of the medication.

May be specific situations when verbal orders are NOT acceptable and if your state allows UDDP to take them or if can do so in certain situations.

MANAGING MEDICATIONS FROM APPOINTMENT

- Individual sees physician
  - May be initial, follow up, intermittent, or routine visit
  - May be PCP, NP, ER Physician, Follow up from ER with PCP or specialist.
  - Emergent situation vs. routine appointment
    - Process is the same
      - Ensure ALL medications are presented (all routine, PRN, vitamins, minerals, herbal, -prescription for agency (does pharmacy provide), but if accompanying someone who self-administers-(ensure able to speak on their behalf, if necessary) and include all meds
      - COMMUNICATE
      - Share MAR/TAR for ALL current medications

MANAGING MEDICATIONS

- PRESENT ALL OF THE FACTS
  - Process in place for ensuring all medications and treatments are shared with the prescriber, but also all of the facts for the prescriber to know the accurate picture of the situation.
  - Behavioral issue-Rule out any medical or dental cause of the behavior. Never assume it is just a behavior.
  - Communication from the Nurse/Program Manager
    - Written, call the office, face time/zoom while at appt, etc. think outside the box on how to communicate, TALK/INFORM staff that will accompany the individual beforehand.
  - Know that the staff's opinions on a situation can persuade the prescriber to prescribe potentially unnecessary medications (good vs bad)

PROMOTE MEDICATION EXPECTATIONS

Complete an accurate listing of all current medications and dosages are available during all transitions of care. (e.g., admission into hospital, change in level of care, discharge, transfer of patients to new sites of care).

MANAGING MEDICATIONS

- ENSURE ALL PRESCRIPTIONS GO TO THE PHARMACY
  - ALL medications should go to your primary pharmacy to ensure all medications are maintained in the individual's profile, but most importantly to compare current medications for potential interactions and to verify no allergy to the medication being prescribed.
    - Take to local on Friday night-lose this process unless your pharmacy is set up to manage this.
- ALL MEDICATION ORDERS VERIFIED BY PHARMACY AND TROUBLESHOOT FOR POTENTIAL ISSUES – INCORRECT/INCOMPLETE ORDERS, UNCLEAR DIRECTIVES OR SPECIFICS NEEDED FOR MED ADMIN BY UDDP.

PROMOTE MEDICATION EXPECTATIONS

The work environment should be considered when assessing safety of the drug administration process.

Factors such as lighting, temperature control, noise level, and potential for distractions (e.g., telephone and personal interruptions, performance of unrelated tasks, and others) should be examined.

Sufficient staffing and other resources must be provided for the given workload.

And WHAT is the biggest distraction of all?

PROMOTE MEDICATION EXPECTATIONS

Data regarding the actual and potential errors of administration should be collected and analyzed for the purpose of continuous quality improvement.

Conduct both initial and ongoing training of staff—including licensed staff, support/non-licensed staff, and relief staff—on accepted standards of practice related to accurate medication administration with the ultimate goal of medication error reduction/ and preferably elimination.

MEDICATION EXPECTATIONS

Periodic review of medication administration throughout the year

Versus

Once a year (with re-certification training)

HELPFUL PHARMACY TIPS TO REDUCE MEDICATION ERRORS

MEDICATION EXPECTATIONS

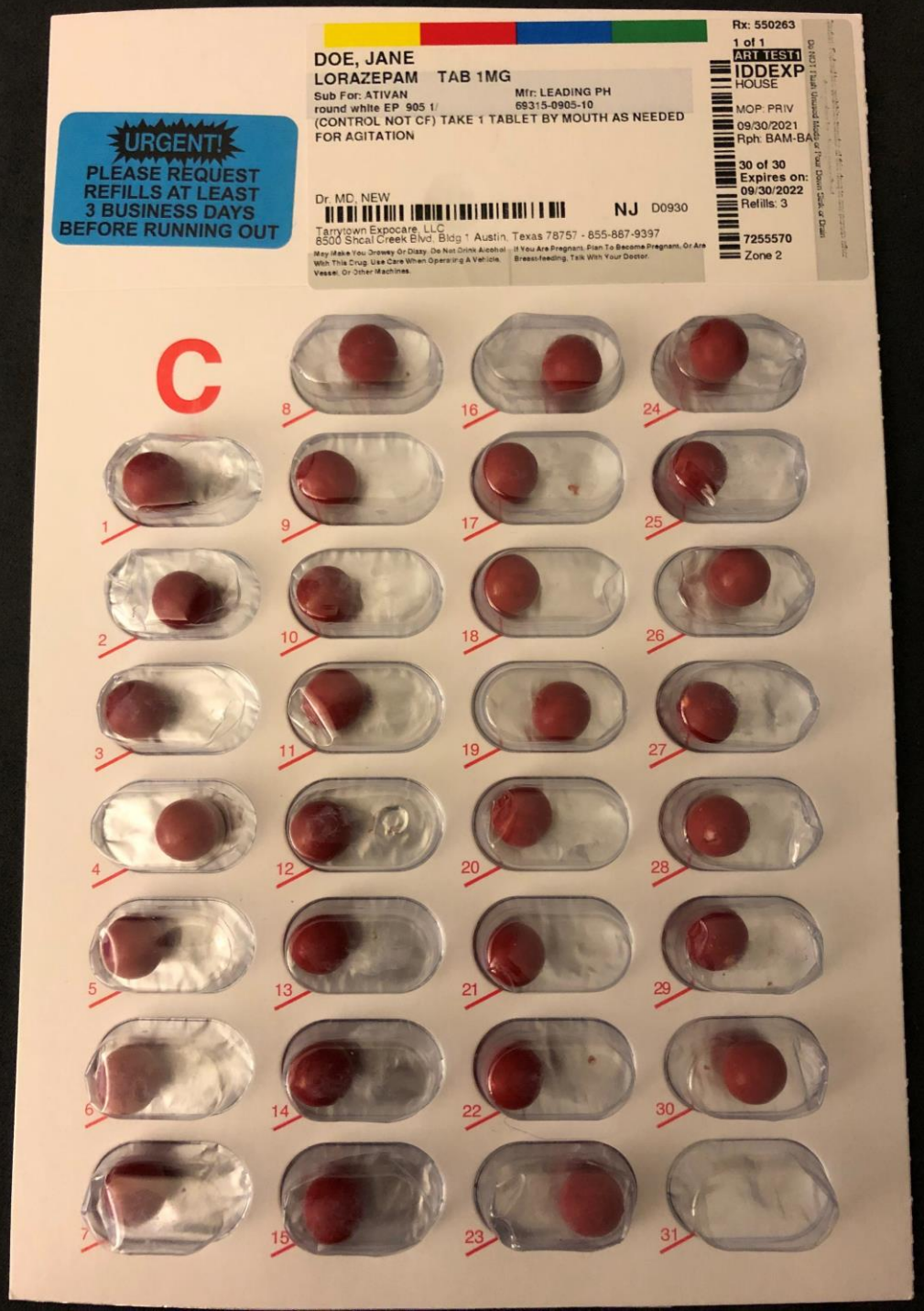
"CROWDED LABELS MAKE IT DIFFICULT TO FIND WHAT IS MOST IMPORTANT," CHAN SAID. "EXEMPTIONS ARE NOT AVAILABLE WHEN LABEL SPACE IS AVAILABLE." FDA WOULD ALSO LIKE "EASY-TO-READ FONT" TO BE USED, SUCH AS A 12-POINT SAN SERIF, WHEN SPACE IS AVAILABLE. THERE MUST BE "ADEQUATE LEGIBILITY," CHAN SAID. TALL-MAN LABELING, IN WHICH DISSIMILAR LETTERS ARE PLACED IN CAPS TO AVOID MIX-UPS BETWEEN TWO LOOK-ALIKE NAMES, AS WELL AS DIFFERENTIATING BETWEEN DIFFERENT PRODUCT STRENGTHS, CAN ALSO BE HELPFUL.

MEDICATION EXPECTATIONS

Single dose packaging of medications

Versus

Multi dose packaging


DOE, JANE
LORAZEPAM TAB 1MG
Sub For: ATIVAN
Mfr: LEADING PH
round white EP 905 1/
69315-0905-10
(CONTROL NOT CF) TAKE 1 TABLET BY MOUTH AS NEEDED FOR AGITATION
Dr. MD, NEW
NJ D0930
Tarrytown Expocare, LLC
8500 Shoal Creek Blvd, Bldg 1 Austin, Texas 78757 - 855-887-9397
May Make You Drowsy Or Dizzy. Do Not Drink Alcohol With This Drug. Use Care When Operating A Vehicle, Vessel, Or Other Machines.
If You Are Pregnant, Plan To Become Pregnant, Or Are Breast-feeding, Talk With Your Doctor.
URGENT!
PLEASE REQUEST REFILLS AT LEAST 3 BUSINESS DAYS BEFORE RUNNING OUT
Rx: 550263
1 of 1
ART TEST
IDDEXP
HOUSE
MOP: PRIV
09/30/2021
Rph: BAM-BA
30 of 30
Expires on: 09/30/2022
Refills: 3
7255570
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Do NOT Flush Unused Meds or Pour Down Sink or Drain
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08:00 AM

DOE, JANE

LEVETIRACETA TAB 1000MG

Sub For: KEPPRA
oblong white H 91/91

Mfr: CAMBER PHA
31722-0539-60

TAKE 1 TABLET BY MOUTH TWICE DAILY

Dr. MD, NEW

NJ D0611

Tarrytown Expocare, LLC
8500 Shoal Creek Blvd, Bldg 1 Austin, Texas 78757 - 855-887-9397

May Make You Drowsy Or Dizzy. Check With Doctor Before Drinking Alcohol. Use Care When Operating A Vehicle, Vessel Or Other Machines.

This Medicine May Be Taken With Or Without Food

Rx: 629581
1 of 2
ART TEST1
IDDEXP
HOUSE
MOP: PRIV
06/08/2021
Rph: WA-WA
15 of 30
Expires on:
09/30/2022
Refills: 0
6590362
Zone 2

Do NOT Flush Unused Meds or Pour Down Sink or Drain

MEDICATION EXPECTATIONS

Safety of medication administration is the priority and ways to support administration according to law and rule/curriculum is of utmost importance.

If in doubt, check it out-BE SAFE-ASK!

Alex's Story-our children's lives are in your hands!

100% sure of what we should/need to do!

MEDICATION EXPECTATIONS

THANK YOU!

Deb Maloy, RN, CDDN
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Next Month's Webinar: 5/10/22
Alzheimer's Disease

BECOME A MEMBER OF DDNA AND NETWORK WITH OTHERS!
IT'S NOT JUST FOR NURSES!

DDNA.ORG

Developmental Disabilities Nurses Association