

# Medication Technician Training Program

## Review



Revised 9/2014

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## Definitions

**CMT:** **Certified Medication Technician** – certified by the MBON to give medication in a DDA setting.

**CNA:** **Certified Nursing Assistant** – a person trained to assist nurses in care of individuals – bathing, vital signs, repositioning – does NOT give medication.

**LPN:** **Licensed Practical Nurse** – licensed professional who works under the direction of an RN.

**RN:** **Registered Nurse** – licensed professional who gives care, directs care, and manages care of patients and individuals.

**CMDN:** **Case Manager Delegating Nurse:** An RN who completes the required DDA training to manage the healthcare of individuals and delegates medication administration to qualified CMT's.

**DDA:** **Developmental Disabilities Administration**

**HCP:** **Health Care Professional** – doctor, nurse practitioner, physician's assistant.

**MBON:** **Maryland Board of Nursing**

## Four Basic Rules

\*You will be required to know these rules for your written exam\*

1. Unlicensed persons may administer medications **ONLY** after successful completion of the MTTP and certification by the MBON as a Medication Technician.
2. Only Registered Nurses (RN's), may delegate administration of medication to CMT's who work in DDA community based programs.
3. All prescription medications must have a physicians order and a pharmacy label to be administered.
4. All **over the counter** medications must have a physicians order and a pharmacy label to be administered.

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“**Over the counter**” medications refer to medications that would normally be purchased at any pharmacy without a prescription – but because of COMAR and DDA regulations , a prescription is required in community based programs.

The Maryland Board of Nursing sets the standards to govern administrations of medication in Maryland. These standards are written in the Nurse Practice Act, which is part of COMAR – the Code of Maryland Regulations. The regulations state that medication administration is a nursing act. Nursing acts can be delegated by an RN to someone who they approve as being prepared and qualified. In DDA-licensed programs, the qualified person must be a Certified Medication Technician (CMT), who has completed a DDA-approved medication technician program.

# CMT Responsibility

\*may need to know one or more for the exam\*

- The CMT is responsible for obtaining physicians orders (PMOF) for medications and treatments as well as a completed medical appointment record whenever you accompany someone on an appointment with his/her HCP.
- Medications must be re-ordered at least every 90 days. Orders can be signed without an appointment, by fax. Check with the nurse if you have a question about this.
- CMT's may NEVER take orders verbally or by telephone. All orders must be written and signed by the HCP.
- CMT's are never authorized to give medication intravenously, through an I.V.
- Pharmacy labels must never be altered by the CMT. Not even the CMDN can do this.
- Individuals have the right to refuse medications and services. Staff has an obligation to work with the person to determine the reason for refusal. CMT's may not hide medication in food, or disguise it in any way.
- CMT's are certified not *licensed* to give medications under the delegating of a licensed registered nurse.

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It is your responsibility as a CMT to maintain your certification by taking the 4 hour Medication Update class every two years prior to your expiration date. The expiration date is based on birth month. The certification will expire on the 28th day of the individual's birth month. An individual born on an even year will renew in an even year. An individual who was born on an odd year will renew in odd year.

You can renew your certification as early as 90 days prior to expiration, but must be completed no later than the month you expire. If missing the Medication Update class results in your certification expiring, you will be required to repeat the entire 20 hour medication class.

If you fail the Update class, you will have one more opportunity to pass as long as you will not expire before the next class is offered. If you fail to attend the second class, you will be required to repeat the 20 hour medication class.

If you fail a second update, you will be required to obtain written permission from your supervisor, the PA, and the delegating RN before another opportunity can be given.

# When to Call the Nurse

Delegating RN: \_\_\_\_\_

Weekend on Call: Friday 6pm to Sunday 6pm 202-258-4842

## Health and safety of individuals – ALWAYS contact the nurse.

- When someone is sick, has a cough, is vomiting, runny nose, diarrhea more than 2 times, seizures, refusing to eat, or refusing to take their medication.
- When someone has not had a bowel movement in 2 days.
- An individual has any illness, any injury, or other change in health status.
- An individual has a fall, been hit, or may have been exposed to a dangerous situation – ie: heat or cold exposure, eaten non-food items, etc..even if they seem fine at the time – YOU NEED TO CALL THE NURSE!
- If you have any questions about medications or health care.
- If you suspect someone has neglected or abused an individual.
- **WHEN IN DOUBT, CONTACT THE NURSE**

## Medications- ALWAYS contact the nurse.

- When a new medication is ordered, or an old one discontinued, or changed.
- Before you post a new medication or discontinue an old one.
- When there has been a medication error.
- If a new medication does not specify a clock time, CALL THE NURSE for directions.
- A medication needs to be crushed, broken, or added to food.
- A PRN medication is needed – you must call to get permission to give it!
- A medication needs to be given outside the regular time frame – (one hour before the scheduled time, or one hour after.)
- If you are unsure how to give a medication or whether you should give it.
- Any questions regarding medication.
- **WHEN IN DOUBT, WHEN YOU HAVE QUESTIONS, CONTACT THE NURSE**

# When to Call the Nurse

## Hospital/Emergency- ALWAYS contact the nurse.

- When someone needs ER treatment, first call 911 THEN contact the nurse.
- When someone is admitted to the hospital. If it happens over the weekend, first call the on call nurse, then call and leave delegating RN a message.
- **BEFORE** you pick up someone who has been discharged from the Hospital.
- **WHEN IN DOUBT, CONTACT THE NURSE**

## What to do when you cannot reach your nurse....

**If this is an emergency** – should you call the nurse or should you call 911?

If this is a true medical emergency: seizure lasting longer than five minutes, bleeding that will not stop, any injuries involving the neck or head, an unconscious consumer, chest pain, or a consumer who is having trouble breathing, you should be calling 911.

**If this is not an emergency** – wait 20 minutes for your nurse to respond then call her back. If you still cannot reach the nurse, call another nurse from the list:

Charity Alwell, RN	301-538-1911
Georgia Chiamba, RN	301-526-0697
Melissa Fisher, CRNP	443-254-1650
Michelle Howell, RN	301-332-9967
Sara Tongue	240-478-3265

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# Reporting Changes

**What** to do.....**Who** to call.....**When** to call.....**How** to report

You will report changes in the physical and behavioral status of the persons you support according to whether the changes represent an **emergency condition**, a **non-emergency condition**, or other **physical/behavioral changes**.

## EMERGENCY CONDITIONS

**WHO:** First 911, then delegating nurse and supervisor

**WHEN:** Immediately

**HOW:** First call 911, then call delegating nurse and supervisor. Last is incident report.

The following are examples that are always emergencies. There may be others. If in doubt, treat the situation as an emergency and report immediately.

- Not breathing, difficulty breathing, severe wheezing, shortness of breath, irregular breathing.
- No heart beat or pulse.
- Loss of consciousness (unless during a seizure with expected recovery)
- Uncontrollable bleeding.
- Accidents with severe injury.
- Seizure lasting longer than 5 minutes, 2 or more back-to-back, in water, new onset, in a person with diabetes, in pregnancy, or failure to return to normal breathing and/or failure to respond within a few minutes after the seizure.
- Sudden numbness or loss of function of a part of the body or slurring of speech.
- Sudden onset of severe headache
- Chest pain
- Drowning
- Electrical Shock
- Eye injuries
- Choking
- Behavior which is uncontrollable or a danger to others.





# Identifying Effects of Medications

When medications are used to cure, prevent, or relieve symptoms of illness, or to manage an illness or related behavior, the medication may have any of three main effects:

1. **Desired effect** – the medication does what it is intended to do.
2. **Unwanted/side effect** – the medication has effects instead of or in addition to the intended effect. Unwanted/side effects may be expected or unexpected. They can range from being harmless to being fatal.
3. **No apparent effect** – the medication does not produce the intended outcome.

**The CMT has the responsibility to observe for these effects in every individual who takes medications. The CMT must also report and document the observed effects to the HCP who ordered the medication and to the delegating nurse.**

## **Desired effect:**

- An anticonvulsant medication is taken for seizures, and the seizures become less frequent or severe.
- Motrin is taken for pain of arthritis, and the pain lessens.
- Cough syrup is given for a cough and the coughing stops.

## **Unwanted/side effect:**

- Amoxicillin is taken to treat an infection, but the individual has diarrhea after 2 doses.
- Dilantin is taken to treat seizures, but the individual experiences nausea and vomiting after taking several doses.
- Benadryl is taken for seasonal allergies, but the individual becomes sleepy about an hour later.
- *In some cases, the effect may be an allergy to the medication. They may include rash, itching, swelling of the face and throat or other parts of the body, wheezing, shock, and sudden death. If someone has an allergic reaction to a medication, they should never take it again.*

## **No apparent effect:**

- Tylenol is taken for a fever of 101, but the fever is still 101 after two hours.
- Zocor is started for high cholesterol, but lab work 3 months later indicates no significant change in the cholesterol level.

# Medication Administration Process

1. Wash Hands
2. Check PMOF, MAR, and pharmacy LABEL – 3 way check
3. Check for drug allergies – (If you work with the same people every day, you should know these like you know your own!)
4. Assemble Equipment
  - Drinking cups, medicine cups, paper towels, water, gloves.
  - Avoid distractions, interruptions
5. Read the label three times
  - 1) When removing the medication from storage – part of the 3-way check.
  - 2) When pouring/popping the medication
  - 3) After pouring but before administering (Last chance!)
6. Prepare ACCURATE dose of medication
7. Administer the medication to the right person
8. Dispose of used cups and other equipment, put medications away.
9. Record administration – “Sign Off” on the MAR
  - Always use black ink
  - Never use white out
  - Call the RN if you think you have documented in error.
10. Clean all equipment and area.

## Key Principles of Hand Washing

- Handwashing is the single most important and effective means of preventing spread of germs (bacteria and viruses) and infection.
- Use liquid soap from a dispenser never use an individual's personal bar soap for yourself.
- Use a good hand lotion – preventing your skin from drying and cracking.
- Antiseptic solutions can irritate the skin – so alternated with hand washing.
- Keep fingernails short and trimmed.

## When to Wash Hands?

- Beginning and end of your shift.
- Prior to medication administration
- Between assisting individuals with any personal care or hygiene.
- When possible exposure to body fluids.
- When possible exposure to articles soiled with body fluids.
- Before or after touching wounds, handling feeding pumps
- Before or after cooking food, serving food, or assisting individuals with feeding.
- Before putting on gloves and after taking them off.
- **WHEN IN DOUBT WASH YOUR HANDS!**

Hand washing exercise.



## The Six Rights

\*You will need to memorize these for our exam\*

1. Right Person
2. Right Medication
3. Right Dose
4. Right Time
5. Right Route/method
6. Right Chart

Each time you administer ANY medication to any individual, you must conscientiously check your procedures using these six rights. There is always the possibility that some change has been ordered or that you accidentally picked up the wrong container.

ANY violation of these six rights constitutes an error in the medication administration procured.

**YOU MUST CHECK FOR ALL SIX RIGHTS EACH TIME YOU ADMINISTER A MEDICATION TO ANY INDIVIDUAL.**

## 3-Way Check

Do the “3-Way Check – read carefully and compare.....

- **MAR**
- **PMOF**
- **Pharmacy Label**

All three must have the same information regarding the **PERSON**, the **MEDICATION**, the **DOSE**, the **ROUTE/METHOD**, and the **TIME**. Double check each item and make sure they agree. Check it one more time before you administer the medication. If they do NOT AGREE, stop and call your delegating nurse to get directions on how to proceed.

When should you do the three way check?

- When the monthly supply of medications arrive.
- When a refilled medication arrives.
- When a new medication arrives.
- Before administering a medication.

Always check the expiration date on the label. if the medication has expired STOP! Contact the delegating nurse.

Some medications have to be ordered regularly, and are not on cycle. Make sure that there is always a fresh supply by checking for expiration and ordering before they run out.

## **Safety Principles – Beyond the “Six Rights” ...**

*\*you will need to list three of these for your exam\**

There are certain things that you can do to help maintain the safety of the environment during medication administration. This will help reduce the risk of medication errors, and possible harm to the individual that can come from an error.

- ✓ **Always give your full attention to the task.**
- ✓ **Avoid distractions and interruptions, no telephone, no television during medication administration.**
- ✓ **DO YOUR THREE WAY CHECK each time you administer medications, and do it three times, comparing the MAR, PMOF, and PHARMACY LABEL.**
- ✓ **Wash your hands before administering medication to EACH individual.**
- ✓ **Never prepare medication ahead of time.**
- ✓ **Prepare medications for one person at a time.**
- ✓ **CHART IMMEDIATELY after you have given medications.**
- ✓ **Chart only medications you have given.**
- ✓ **Administer medications that YOU have prepared.**
- ✓ **Do not touch medications with your hands.**
- ✓ **Stay with the individual until the medication is taken and swallowed.**
- ✓ **NEVER leave medication unattended.**
- ✓ **Do not give medication that has expired, has outdated orders, or has changed color.**
- ✓ **Administer medications only from labeled pharmacy packages.**
- ✓ **Never dispense medication into another container to be given at another location (LOA), or at a later time. Discuss with the delegating nurse.**
- ✓ **When in doubt about anything, call your delegating nurse.**
- ✓ **NEVER HIDE – ALWAYS REPORT – A MEDICATION ERROR.**

## **Medication Errors: When the Rights go Wrong.....**

- All medication errors must be reported to the delegating or on call nurse immediately, then to the supervisor.
- Medication errors are reportable incidents.
- Medication errors must be documented on the MAR.
- The delegating nurse will determine if it is necessary to contact the HCP, and will give the staff instructions for required medical follow up if necessary.

### **Medication errors include, but are not limited to the following:**

- Failure to administer the prescribed medication for one or more dosages.
- Medication given to the wrong person.
- Wrong medication given.
- Wrong dose given.
- Medication given at the wrong time.
- Medication given by the wrong route, or in an incorrect form.
- Medication given without a prescription or physician's order.
- PRN medication given without permission of the RN.
- Medication not charted properly.
- Medication given when allergy to the medication is documented on the record of the individual.
- Discontinued medication given.
- Medication not obtained and started in a timely manner.
- Supervisor not contacted in absence of a CMT to administer medications.
- Administering medications without the approval of a delegating RN.
- Off site, or day program medication not provided properly.
- Failure to report a medication error to the delegating RN or supervisor.
- Medication given when the PMOF, MAR, and/or pharmacy label do not match.
- Medication stored improperly.
- Failure to ensure adequate supply of medication.
- Medication given when "on hold" under HCP's or nurse's instructions.
- Breaking, crushing, dissolving, or mixing a medication with food without first consulting the delegating nurse.

## Documentation Exercise

- Holly Adams is a woman who was born 11/4/55.
- She has a diagnosis of intellectual disability, constipation, seizures, psychosis, and congestive heart failure (CHF).
- Her diet is regular, high fiber.
- Her doctor is Dr. Arnold Day, her nurse is Nancy Nurse, RN
- She is allergic to penicillin.
- She likes to watch television, go to concerts, and the movies. She doesn't like sleeping in the dark or broccoli.
- Use this month and year for your dates.
- Fill out the blank MAR with Holly's information.