Back to the Basics: *Overview of Medication Management in Assisted Living*

Sponsored by

Presenters:

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Objectives

- Understand the regulations that guide safe medication management in assisted living.
- Recognize the roles and responsibilities CMAs and nurses in medication assistance and oversight.
- Strengthen clinical and educational practices around insulin use and vaccine education to promote resident safety and wellness.

Today's Plan

Understanding the Regulations

Applying the Rules

Safe Medication Handling & Documentation

Clinical Practice & Resident Safety

Understanding the Regulations

- Assisted Living Communities 902 KAR 20:480
- Certified Medication Aide 201 KAR 20:700
- Delegation of Nursing Tasks 201 KAR 20:400
- Tuberculosis Testing 902 KAR 20:200 and 902 KAR 20:205
- Immunization Requirements for Long Term Care Facilities 902 KAR 2:065

Assisted Living Communities Regulation 902 KAR 20:480

Defines standards for:

- Medication **storage**, **labeling**, and **administration**
- Staff **training** and **supervision**
- **Documentation** of medication assistance and oversight

Medication Management Services (Section 15) **applies to facilities licensed to operate as an ALC-BH or ALC-DC**

Definition: Medication Management

KRS 194A.700(18)

"Medication management" means the provision of any of the following medication related services to a resident:

- Performing medication setup
- Administering medications
- Storing and securing medications
- Documenting medication activities
- Verifying and monitoring the effectiveness of systems to ensure safe handling and administration
- Coordinating refills
- Handling and implementing changes to prescriptions
- Communicating with the pharmacy about the resident's medications and
- Coordinating and communicating with the prescriber

Resident Assessment

Before providing medication management services:

- A **nurse or other licensed health professional** must complete an assessment.
- The assessment must be **face-to-face with the resident.**
- It determines **what medication services are needed** and **how they will be provided.**

Reassessment:

- Required **if the resident shows changes or medication-related issues.**
- Must occur **at least once every 12 months.**

Medication Storage

Keep all medications locked and secured at all times.

Refrigerated medications must be stored in a **separate locked box** within the medication refrigerator.

External-use drugs (creams, ointments, eye drops, etc.) must be **stored separately** from oral or injectable medications.

Controlled substances require a **double lock system** with access limited to authorized staff only.

Staffing

Supervision of an unlicensed staff person performing medication or treatment administration:

- Shall be provided by a **nurse or appropriately licensed health professional** and
- May include **observation** of the staff person administering the medication or treatment and the interaction with the resident.

Controlled Substance Recordkeeping

A bound record book with numbered pages must include:

- **Resident name**
- **Date, time, drug name, dose, and method** of administration
- **Prescribing practitioner's name**
- **Name of the nurse or CMA** who:
  - Administered the medication, **or**
  - Assisted with self-administration under a documented determination that the resident can safely self-administer

Controlled Substance Counts and Disposal

- A **licensed health professional** must maintain a **signed count record** for all controlled substances:
  - **Schedule II** – counted **daily**
  - **Schedules III–V** – counted **at least weekly**
- **Expired or discontinued medications** must be:
  - **Disposed of or destroyed within 30 days**, and
  - Done **according to DEA-approved methods for destroying controlled substances** (for example, witnessed destruction or transfer to a reverse distributor).

Certified Medication Aide Regulation 201 KAR 20:700

Certified Medication Aides (CMAs) are unlicensed professionals who work in long-term care facilities and help with medication administration

CMA I and CMA II credential holders may administer medications under the delegation of a nurse within limits

2 Classes of Certified Medication Aides

CMA I: can ***administer oral and topical medication*** in a long-term care facility with KBN-approved training

CMA II: can also ***administer preloaded insulin injections*** with KBN-approved training

Delegation of Nursing Tasks Regulation 201 KAR 20:400

A nurse **may delegate** specific nursing tasks to trained, competent CMAs.

The **nurse retains accountability** for outcomes.

The goal is **safe, effective care** while allowing team members to work at the top of their role.

Criteria for Delegation

Tasks must be **routine, predictable, and low-risk.**

The nurse **cannot delegate tasks requiring nursing judgment** (e.g., assessments or PRN decisions)**.**

The nurse must **verify and document competency** before delegation.

Controlled Substances

For a controlled substance ordered on a PRN basis, a nurse may delegate administration to a CMA if:

- The nurse assesses the resident, in person or virtually, prior to administration of the PRN controlled substance
- The nurse documents administration of the PRN controlled substance by a CMA in the resident's record

Tuberculosis Testing Regulations 902 KAR 20:200 and 902 KAR 20:205

For Residents and Staff:

- **Two-step test** required on **admission or hire** *(if using TST)*.
- **One-step test** acceptable if using a **blood assay (BAMT)**.
- Must complete a **TB Risk Assessment** for everyone tested.
- May accept **recent results (within 3 months)** from another facility if part of a serial testing program.

Ongoing Testing and Documentation

The **initial TST** may count as the **second step** if it was negative and given within one year.

Must provide **annual testing** and risk assessment.

- Must complete these **in or before** the same month as the last test.

Record both the **test results and risk assessment** in the medical record.

Immunization Requirements
Regulation 902 KAR 2:065

Residents and staff must receive **influenza** and **pneumococcal** vaccines.

- **Influenza:** Each flu season by **October 15** or at **admission/hire**.
- **Pneumococcal:** At **admission/hire** and kept on file.

Exemptions: Allowed for **medical, religious, or informed refusal** — must be **documented**.

OVERVIEW OF MEDICATION MANAGEMENT IN ASSISTED LIVING

Presented by: Dewayne Reneer RN and Tiffany Patrick RN

SECTION #2 APPLYING THE RULES: SAFE MEDICATION HANDLING AND DOCUMENTATION

Goal: Translate the regulations into daily operations and documentation systems

Topics:

- Setting up compliant medication storage and labeling
- Documentation of medication administration, refusals and disposal
- Proper disposal of discontinued or expired medications
- Recognizing and preventing medication errors
- Establishing a system for timely reporting and follow up

PRINCIPLES FOR COMPLIANT MEDICATION STORAGE: CORE ELEMENTS

Secure: locked medication room, cart or cabinet with controlled access (key/fob/keypad)

PRINCIPLES FOR COMPLIANT MEDICATION STORAGE: CORE ELEMENTS

- Separate locked storage: for controlled substances (double-locked)

PRINCIPLES FOR COMPLIANT MEDICATION STORAGE: CORE ELEMENTS

- Environmental controls: temperature logs for items requiring refrigeration, medications protected from light/humidity

TEMPERATURE LOG FORM

Synchrony PHARMACY

Month/Year: _____ Facility Name: _____

Recommended Fridge Temperature Range: 36° F – 46° F (2° C – 8° C). Recommended Med Room Temperature Range: 68° F – 77° F (20° C – 25° C), with only brief deviations to not exceed 59° F – 86° F (15° C - 30° C)

Day:	Time:	Med Room Temp:	Fridge Temp:	Initials:	Time:	Med Room Temp:	Fridge Temp:	Initials:
1								
2								
3								
4								
5								
6								
7								
8								
9								
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Retain all temperature Logs for no less than one year.

FAX COMPLETED LOG TO THE PHARMACY AT END OF EACH MONTH

PRINCIPLES FOR COMPLIANT MEDICATION STORAGE: CORE ELEMENTS

- Limited access: only authorized personnel (documented) should have access to or handle medications
- Inventory system: running counts, reconciliation with pharmacy deliveries, discrepancy procedures

PRINCIPLES FOR COMPLIANT MEDICATION STORAGE: CORE ELEMENTS

- Drugs for external use must be stored separately from those given by mouth or injection
- Carts/storage area must be well-lighted and of sufficient size to allow storage of the medications without crowding
- Medications must remain in the original container with original prescription label
- Medications no longer in use or expired must be properly disposed of per facility policy in accordance with all applicable state/federal laws

MEDICATION LABELING

Standard prescription medication label includes:

1. Residents/patients full name
2. Pharmacy name, address and phone number
3. Prescription (RX) number
4. Drug Expiration Date
5. Prescription Expiration Date
6. Quantity Dispensed and remaining refills
7. Prescribing Provider
8. Dispense Date
9. Full directions for use
10. Medication name, strength and dose

#1
Residents/patients Name

#10
Medication name strength and dose

#9
Directions for use

#8
Dispense Date

#7
Provider

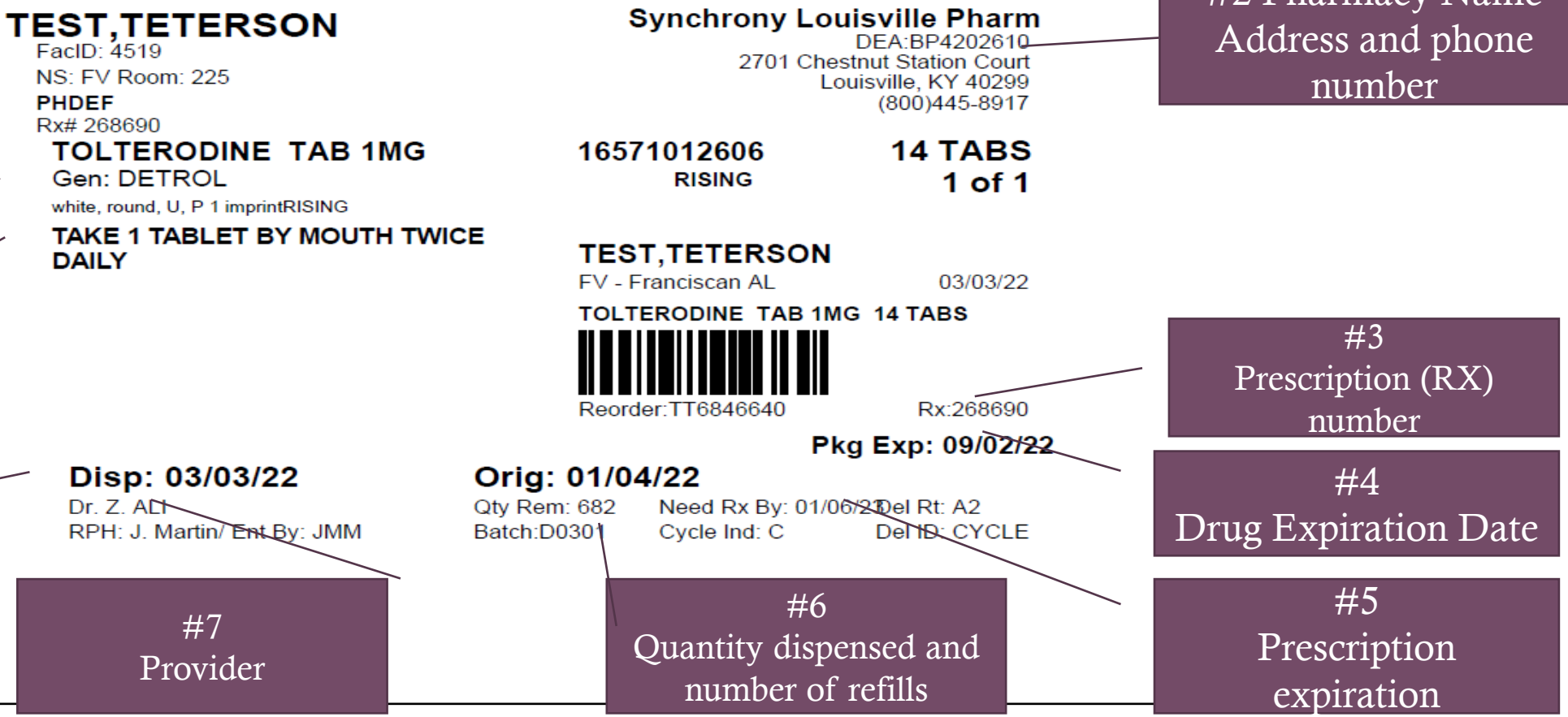
#6
Quantity dispensed and number of refills

#5
Prescription expiration

#4
Drug Expiration Date

#3
Prescription (RX) number

#2 Pharmacy Name Address and phone number



MEDICATION LABELING

- Over-the-Counter medications: facilities may allow residents to bring in their OTC medications, when an OTC medication is brough into the facility, the following information should added to the medication container; the resident's name, prescriber's name and see MAR for directions (do not cover any of the manufactures information when adding the additional information)
- Any medication container with an illegible, damaged or incomplete label, should be returned to the pharmacy for relabeling or disposed of per facility policy
- Consider Barcode scanning where available (Pro: can reduce medication errors Con: can be expensive to maintain)

LABELING SPECIAL CONSIDERATIONS

- Many medications have different expiration dates based upon when the product is opened vs unopened.
- Medication expiration dates are determined based on storage within specified manufacturers-defined temperature control ranges. Exposing medication to temperatures outside of these ranges can cause them to degrade, potentially become less effective, which may shorten their effective shelf life before the printed expiration date.
- In these instances, the date the medication is opened should be documented on the medication to ensure the medication is not used outside of manufacturer's FDA approved labeling.
- These medications are called short shelf-life medications
- Examples of short shelf-life medications
  - Inhalers
  - Eye drops
  - Insulins
  - Liquid Medications

MEDICATION DOCUMENTATION: WHY THIS MATTERS

- Medication-related tasks (administrations, omissions, destructions) are high-risk in healthcare
- Accurate, timely documentation underpins patient safety, clinical decision-making, legal and regulatory compliance and continuity of care
- Inadequate documentation contributes to errors, omissions, miscommunications and potentially harm

MEDICATION ADMINISTRATION DOCUMENTATION

- The process of administering a medication isn't complete until the action is documented
  - Medications are to be documented as they are administered IMMEDIATELY after administration
- Accurate documentation ensures the "rights" of medication administration are captured (Right patient, Right medication, Right dose, Right route, Right time, Right documentation)
- For every medication administered: staff must document in the residents record the medication name, dosage, date, time, method/route of administration, signature and title of staff.
  - Required Pre or Post Assessments (Vital Signs), Pain scores/assessments
  - Residents' response to the medication: side effects, adverse effects
- Documentation serves as a communication tool for the interdisciplinary team, continuity of care, legal evidence and quality assurance

MEDICATION ADMINISTRATION DOCUMENTATION FOR PRN MEDICATIONS, REFUSALS, LATE/DELAYED DOSES

- PRN
  - Medication must include an indication for use
  - Document response
- Refusals
  - Documented date and time of refusal, reason for refusal, encourage and discuss the consequences of the refusal with the resident
  - Provider notified and Responsible party/POA notified if applicable (documented including time of notification)
- Late/Delayed Doses
  - Documented reason
  - Provider notification

DOCUMENTATION BEST PRACTICE

- Document as soon as possible after administration (timely)
- Ensure all entries are legible
- Use approved abbreviations only; avoid shorthand
- Ensure the documentation includes patient identifiers, drug name, strength, route, time, and any pre or post assessments, side-effect or adverse effects

RISK SURROUNDING POOR DOCUMENTATION

- If a dose is not documented, the next shift may think it is pending - risk of receiving a double dose of medication
- If a patient's response, side-effect or adverse-effect isn't recorded, treatment changes may be delayed or inappropriate
- Incomplete/illegible entries, use of non-approved abbreviations can lead to misinterpretation

MEDICATION OMISSIONS AND REFUSALS

- A medication omission refers to a dose not given when scheduled (for whatever reason). A refusal is when the patient declines the medication
- It is just as important to document why a dose was omitted or refused as it is to document when it was given. For example: “Missed/refused medication must be documented in the resident’s medication record and the prescribing physician contacted immediately.”
- Documentation supports safe hand-over and continuity: if a dose was omitted, future care providers must know this is to adjust monitoring, dosing or education accordingly

RISK OF POOR DOCUMENTATION

- Without the documentation, omissions may no be noticed and hence not addressed leading to a possible treatment failure or adverse outcome
- Other staff may assume medication was given and not check, or assume omission was reported and take no action
- Legal/regulatory risk: if documentation is missing it may be recorded as “not administered” (or presumed given) with no rational

BEST PRACTICE TIPS

- If a medication is omitted or refused: document time, reason (patient asleep, pt refused, medication unavailable) any action take (called pharmacy, notified provider).
- Flag the omission/refusal so it is visible to the care team
- Follow any organizational policy for communication, monitoring and follow-up.

COMPLIANT MEDICATION DISPOSAL

- When medications expire, are discontinued or unused, they must be destroyed or returned/disposed per state/federal regulations.
- Facility must develop policy and procedures around medication destruction/disposal
- Method of destruction for non-controlled medications
  - Return to pharmacy partner for destruction
  - Physically destroying medication by incineration or chemical digestion
  - Transfer to a reverse distributor
- Methods of destruction for controlled medications
  - Physically destroying medication by incineration or chemical digestion
  - Transfer to a reverse distributor

COMPLIANT CONTROLLED MEDICATION DISPOSAL – DEA APPROVED METHODS

On-site destruction

- **Method:** physically destroy the controlled substance using an on-site method like incineration or chemical digestion
- **Process:**
  - Requires two authorized employees to witness the entire process
  - Must be documented on a destruction log and signed by both witnesses
  - Record retention may vary by state

COMPLIANT CONTROLLED MEDICATION DISPOSAL – DEA APPROVED METHODS

Transfer to a reverse distributor

- **Method:** Deliver the controlled substances to a reverse distributor for destruction
- **Process:**
  - Requires two authorized employees to witness the entire process
  - Must be documented on a log and signed by both witnesses
  - The transfer can be done via a common or contract carrier pick-up or by the reverse distributor picking up the substances
  - If transferring Schedule II substances, the reverse distributor must issue an official order form to the registrant
  - The reverse distributor handles the final, compliant destruction

DOCUMENTATION OF MEDICATION DESTRUCTION (DISPOSAL)

- When medications expire, are discontinued or unused, they must be destroyed or returned/disposed per state/federal regulations. Documentation of this is required by regulation. The documentation must include
  - Resident
  - Medication including strength
  - Quantity
  - Date of destruction
  - Method of destruction
  - Signature of the witnesses performing the destruction
- Proper documentation forms part of the audit trail, helps prevent diversion, ensures compliance with laws/regulations (controlled substances especially) and protects patient safety and organizational accountability.

KEY DOCUMENTATION REQUIREMENTS

- The documentation must include:
  - Resident
  - Medication including strength
  - Quantity
  - Date of destruction
  - Method of destruction
  - Signature of the witnesses performing the destruction
- Records must be retained for a period of time defined by the state

RISK WHEN DISPOSAL DOCUMENTATION IS INADEQUATE

- Medications may not be accounted for – increased risk of misuse or diversion
- Compliance risk: regulatory bodies may find deficiency in procedure/documentation
- Loss of audit trail – inability to demonstrate safe destruction or trace medication history
- Potential environmental or public safety risk if medications disposed incorrectly

BEST PRACTICE TIPS

- Maintain a formal log for destruction/disposition record book with clear fields
- Use secure procedures; separate storage for medications awaiting destruction, locked area, supervisor
- Ensure documentation is completed simultaneously with destruction process signed and retained per policy

MEDICATION DIVERSIONS RECOGNIZING AND PREVENTING: RECOGNIZING

- Observe for:
  - Patients complaining of unrelieved pain despite records indicating receiving medications
  - Frequent errors
  - Incorrect narcotic counts
  - Medications running out or being reordered before they should be based on directions for use
  - Excessive PRN administrations by one staff membered compared to others
  - Evidence of altered mediation packaging (broken seals)
  - Controlled medications destroyed without appropriate witness
  - Changes in staff behaviors or work performance
    - Extended breaks
    - Works overtime and comes in on off days
    - Inappropriate emotional responses

MEDICATION DIVERSIONS RECOGNIZING AND PREVENTING: PREVENTING

- Be familiar with concerning behaviors and practices
- Always maintain custody of the medication keys
- Always complete controlled drug counts any time control of the mediations changes hands
  - Visualize the medication and the count sheets during the controlled medication count
- Always removed discontinued narcotics from the cart as soon as possible
- Ensure staff have been educated to all controlled medication policies and procedures
- Facility clinical leadership should make unexpected rounds/audits on controlled medications

MEDICATION ERRORS RECOGNIZING AND PREVENTING: WHAT IS A MED ERROR – COMMON MED ERRORS

Medication Errors are preventable events that can result in, inappropriate medication use or patient harm while the medication is being managed by a healthcare professional, patient or consumer.

Most Common types of Errors include:

- Administering to the wrong resident
- Wrong dose or strength
- Omission (missed dose)
- Wrong time/frequency
- Wrong route
- Transcription Errors

MEDICATION ERRORS RECOGNIZING AND PREVENTING: RECOGNIZING

Recognizing a medication error involves observing our residents for unexplained changes in their physical and behavioral wellbeing.

- **New or worsening physical symptoms:** Sudden onset of nausea, vomiting, diarrhea, rash, hives, itching, or difficulty breathing.
- **Changes in alertness and cognition:** Unusual drowsiness, sudden confusion, memory trouble, or excessive fatigue.
- **Altered mood or behavior:** Unexpected agitation, nervousness, anxiety, or withdrawal from normal activities.
- **Motor skill issues:** Slurred speech, clumsiness, unsteadiness when walking, new tremors, or muscle weakness.
- **Changes in vital signs:** Rapid heartbeat, significant changes in blood pressure, or chest pain.
- **Lack of improvement:** The patient's condition is not improving as expected, which could indicate they are receiving the wrong medication or an insufficient dose.

MEDICATION ERRORS RECOGNIZING AND PREVENTING: PREVENTING

- Performing Three-checks Comparing the MAR with the medication label
  - Before removing the medication from the cart
  - After removing the medication from the cart
  - After preparing the medication before placing the container back in the cart
- Follow Six Rights of medication administration
  - Right Patient
  - Right medication
  - Right Strength/Dose
  - Right Route
  - Right time
  - Right Documentation
- Confirm resident allergies and medication expiration

MEDICATION ERRORS RECOGNIZING AND PREVENTING: PREVENTING CONTINUED

- Minimize distractions during medication preparation and administration
- Periodic competency checks and documented in-services with staff
- Double checking medication reconciliation at admission, transfer and discharge
- Timely documentation after medication administration

MEDICATION ERRORS RECOGNIZING AND PREVENTING: REPORTING AND FOLLOW-UP

- Encourage non-punitive reporting of medication errors and near misses,
- Stress importance of early intervention with medication errors to prevent resident harm
- Use reporting form
- Conduct root cause analysis
- Implement corrective action

SECTION 3 – APPLYING THE RULES: CLINICAL PRACTICE AND RESIDENT SAFETY

Goal: Strengthen understanding and reinforce safe, resident-centered care practices.

Topics:

- Insulin Administration
  - Types, time, injection technique using a pens
  - Common administration errors and how to avoid them
- Vaccine education and administration
  - Proper resident/staff education about vaccines
  - Documentation of informed consent and education
- Integrating medication management into quality improvement efforts
- Collaboration among the pharmacist, nurse and administrator for quality improvement

INSULIN ADMINISTRATION:

- Insulin is a life-saving medication for residents with diabetes. Safe administration requires understanding insulin types, preparation methods, injection techniques, and timing. Errors in insulin administration can lead to serious complications such as hypoglycemia or hyperglycemia.

INSULIN ADMINISTRATION:

Type	Example	Onset	Peak	Duration
Rapid-acting	Lispro (Humalog), Aspart (Novolog), Glulisine (Apidra)	10–30 min	30 min–3 hr	3–5 hr
Short-acting	Regular (Humulin R, Novolin R)	30–60 min	2–5 hr	6–10 hr
Intermediate-acting	NPH (Humulin N, Novolin N)	1–2 hr	4–12 hr	12–18 hr
Long-acting	Glargine (Lantus, Basaglar)	1–4 hr	No pronounced peak	24 hr
Ultra-long acting	Degludec (Tresiba)	30–90 min	No peak	>42 hr
Premixed	70/30, 75/25	Varies	Dual peaks	10–16 hr

INSULIN ADMINISTRATION: TIMING

- Rapid-acting: 10–15 minutes before meals.
- Short-acting: 30 minutes before meals.
- Intermediate-acting (NPH): Usually twice daily; give before breakfast and dinner.
- Long-acting: Once daily, same time each day.
- Ulta-Long acting: Once daily, same time each day.
- Premixed: 10–30 minutes before meals depending on type.

Always verify facility policy and follow provider order for exact timing.

INSULIN PEN ADMINISTRATION TECHNIQUE:

- Perform hand hygiene.
- Check medication administration record (MAR) to verify order.
- Check for allergies.
- Perform 1st check, checking medication label with MAR.
- Remove insulin pen from the resident's designated area/drawer.
- Perform 2nd check, checking medication label, with medication with MAR.
- Check expiration/open date. If opening a new pen document opening date per facility policy.
- Remove pen cap and inspect the insulin checking color, clarity. Clear insulin should always be clear.
- **Wipe the rubber septum with an alcohol swab.**
- Remove the seal from the new needle.
- Line the needle up straight with the pen and screw the needle on being careful not to screw the needle too tight.
- Remove the outer needle cover and do not throw it away.
- **Dial a 2-unit prime/test dose.**
- Hold the pen upright, lightly tap the pen reservoir so any air bubbles will rise to the top.
- Press the injection button all the way in and verify insulin comes out the end of the needle.
- If you do not see insulin after two tries replace the needle and try again. If you still do not get insulin obtain a new pen.
- You may need to repeat the prime/test dose step 2-3 times on a new pen to get insulin to come out the end of the pen needle.

INSULIN PEN ADMINISTRATION TECHNIQUE CONTINUED:

- After a successful prime make sure the dial is back to ZERO and select the prescribed dose.
- Perform 3rd check, checking that the correct dose is dial up on the syringe, check the medication and label with the MAR.
- Take note of previous injection site and ensure rotation of injection sites per facility policy and procedure.
- Lock the medication cart.
- Proceed to the resident's room.
- Knock, introduce yourself, identify your resident per facility protocol, explain what you are there to do and provide for privacy.
- Position supplies on a clean barrier in reach.
- Perform hand hygiene and don gloves.
- Clean the injection site with alcohol and allow the site to dry.
- Keep the pen straight, insert needle into the skin at a 90-degree angle.
- **Using your thumb press the injection button all the way in until the dial returns to zero, once the dial reaches zero, slowly count to 10 before removing needle.**
- Release injection button and remove needle from skin.
- Use outer needle cover to remove needle and dispose of needle in a sharp's container.
- Dispose of supplies,
- Remove gloves and perform hand hygiene.
- Return medication to the cart.
- Document administration and administration site.

INSULIN ADMINISTRATION: COMMON ADMINISTRATION ERRORS AND HOW TO AVOID THEM

Error	Potential Outcome	Prevention
Wrong insulin type	Hypo/hyperglycemia	Double-check label before each dose
Wrong dose	Severe hypo/hyperglycemia	Use “six rights” (right resident, drug, dose, route, time, documentation)
Missed dose	High blood glucose	Set reminders, use MAR for documentation
Wrong timing	Blood sugar fluctuations	Follow prescribed schedule
Failure to rotate sites	Lipodystrophy	Rotate sites every injection
Mixing wrong insulins	Unstable glucose control	Never mix long-acting with other types

VACCINE EDUCATION AND ADMINISTRATION:

Why Vaccines Matter

- Residents often have weakened immune systems due to age and chronic conditions
- Staff can spread infections even if they have no symptoms
- Vaccinations helps protect
  - Residents from serious illness, hospitalizations and death
  - Staff from missed work and spreading illness
  - Reducing potential for outbreaks

VACCINE EDUCATION AND ADMINISTRATION: EDUCATION

Before Vaccination

- Provide clear education materials (CDC Vaccine information statements)
- Review
  - Purpose of the vaccine
  - Benefits vs risk
  - Possible side effects and what to expect

VACCINE EDUCATION AND ADMINISTRATION: INFORMED CONSENT

- Obtain written consent before administering vaccines
- Document
  - Vaccine type, dose, lot number, manufacturer, and injection site
  - Date and name of administering nurse or pharmacist
  - That education provided and consent was obtained

VACCINE EDUCATION AND ADMINISTRATION: RECORD KEEPING

- Record resident's vaccines in their health record and state immunization registry (if you have access)
- Record staff vaccines in their employee file

VACCINE EDUCATION AND ADMINISTRATION: BEST PRACTICES

- Hold annual vaccine clinics for resident and staff
- Offer on-site education sessions before the clinics
- Create a vaccine tracking log to monitor compliance
- Partner with locate health departments or pharmacies for vaccine supply

INTEGRATING MEDICATION MANAGEMENT INTO QUALITY IMPROVEMENT EFFORTS: PHARMACIST, NURSE AND ADMINISTRATOR

- Integrating medication management into quality improvement ensures safe, effective and resident centered care.
- Consider using a Plan-Do-Study-Act for continuous improvement
- Track key indicators:
  - Medication error rates
  - Timeliness of medication administration
  - Controlled medication discrepancies
  - Resident satisfaction and hospitalization rates
- Review trends at QA meetings

INTEGRATING MEDICATION MANAGEMENT INTO QUALITY IMPROVEMENT EFFORTS: PHARMACIST, NURSE AND ADMINISTRATOR

Role	Primary Function	Quality Contribution
Pharmacist	Clinical review, medication oversight	Reduces adverse events, improves drug regiment effectiveness
Nurse	Safe administration of medication and monitoring	Ensures timely delivery, detects errors early
Administrator	Leadership and Policy enforcement	Sustains quality improvement processes and staff accountability

INTEGRATING MEDICATION MANAGEMENT INTO QUALITY IMPROVEMENT EFFORTS: PHARMACIST, NURSE AND ADMINISTRATOR

Medication management is a central pillar of quality of car

Collaboration among the pharmacist, nurse and administrator will improve outcomes, reduce the likelihood of errors and support compliance

2025 ANNUAL MEETING SESSION 2: BACK TO BASICS: OVERVIEW OF MEDICATION MANAGEMENT NOVEMBER 18, 2025

- ***Scan this code with your phone to access the session evaluation form!***
- **How to scan QR Code:**
- Open camera app
- Point the camera at the QR Code center and focus on code until link pops up
- Tap the notification to open the link (Internet connection required)
- Follow the instructions on the link to complete the training evaluation
- **Samsung/Android users: Hold down the "Home" button and swipe up to reveal the options at the bottom. Select "What's on my screen?"** The short URL connected to the QR Code's information will then appear.
- **To receive full credit for attending today's session you are required to complete within 24 hours of this session.**
- **Please note that you will be required to enter your KBN license number. If you are NAB certified, please enter your full NAB ID to receive credit.**

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