Practical Application and Strategies for Safe Medication Administration

Ohio Assisted Living Association
10:30 a.m. – 12:00 p.m.

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Meet the Speakers

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Tiffany Patrick holds a Bachelor of Science in Nursing from Spalding University. Before joining Synchrony Pharmacy, she served as Director of Nursing Services and Director of Clinical Operations in long-term care and assisted living. In these leadership positions she led her teams through numerous surveys, achieving outstanding results.



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Nurse Consultant, Synchrony Pharmacy

Jeanette Parra holds a Master of Arts in Education Technology from the University of Michigan-Dearborn and a Bachelor of Science in Nursing from the University of Michigan-Flint. With more than 16 years in health care, she brings expertise in dementia care, de-escalation, quality improvement, and staff education. A national presenter with the American Psychiatric Nurses Association, she is known for turning complex clinical concepts into practical, actionable strategies.



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Disclosures

- Tiffany Patrick does not have relevant financial relationships with ineligible companies.
- Jeanette Parra does not have relevant financial relationships with ineligible companies.
- Artificial intelligence, language models, machine learning, or similar technologies were used to create content or assist with the development of this presentation.

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

Objectives

01 Safe Administration

Apply best practices for medication administration to reduce medication errors and improve patient safety.

02 Cart Readiness

Organize and maintain a medication cart to support efficiency, infection prevention, and audit compliance.

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

Objectives

03 Preventing Delays

Implement strategies to prevent medication delays and ensure timely medication delivery.

04 Controlled Substances

Demonstrate proper management of controlled substances, including storage, documentation, reconciliation, and discrepancy resolution.

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

Scan to answer, or go to slido.com and enter code #2173256

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Safe Medication Administration

Objective 1

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1 in 4 doses observed in assisted living had an error

Young et al., 2008

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Why Medication Administration Matters

Resident Safety

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

Effective Treatment

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

Regulatory Compliance and Accountability

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

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The Medication Rights: A Safety Pause

Core Verification: every time, 3 times

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

Clinical Context

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

Rights do not replace clinical judgment; they organize it.

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Before the Medication Pass

Preparation prevents both errors and delays.

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

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5-Minute Start-of-Shift Scan

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

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Verify at the Point of Care

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



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

Westbrook et al., 2010

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Protect the Pass From Interruptions



Signal + Education

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



A Time to Come Back

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



Hold the Non-Urgent

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

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After Administration: Close the Loop

Document

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

Monitor

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

Communicate

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

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Medication Cart Readiness

Objective 2

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Medication Cart Organization

Security

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

Clean & Separated

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

Ready to Use

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

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Audit Readiness: What Reviewers Find

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

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Shift Audit Habit

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

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Preventing Medication Delays

Objective 3

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

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

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Preventing Delays: Anticipate

Treat medication availability as a system responsibility.

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

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Act and Close the Loop

Act

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

Close the Loop

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

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Time-Sensitive Medications

Watch Closely

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

If a Dose Is Late

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

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Controlled Substances

Objective 4

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Secure, Account, Escalate

Secure

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

Account

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

Escalate

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

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

The reconciliation question

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Count & Reconciliation

- Count narcotics at every shift change.
- Verify medication and quantity.
- Reconcile counts with administration records.
- Resolve discrepancies immediately.
- Document all doses, wastes, and returns.
- Secure controlled substances at all times.
- Report suspected diversion promptly.
- Never sign a count you did not verify.



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When the Count Is Wrong

Act immediately, methodically, and without accusation.

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

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Diversion Prevention

Possible Signals

- Repeated discrepancies
- Late/corrected documentation
- Unusual access or wasting
- Resident reports meds not working

System Controls

- Restricted access
- Accurate perpetual records
- Witnessed waste
- Access-log review and audits

Response Culture

- Report promptly and objectively
- Protect confidentiality
- No informal "investigations"
- Follow HR/regulatory procedures

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Medication Errors & Near Misses

- Ensure Resident Safety
- Identify Exactly What Happened
- Review the Medication Order and MAR
- Examine the Mediation and Storage
- Interview the Staff Involved
- Identify Contributing Factors
- Determine the Root Cause
- Develop Corrective Action
- Monitor for Improvement
- Document the Investigation

Use near misses as learning opportunities before harm occurs

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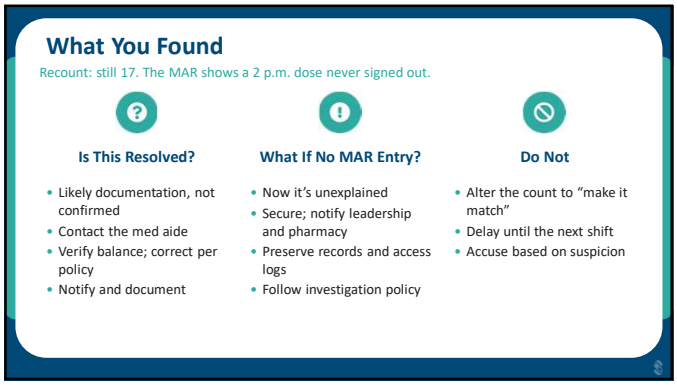
Think of a near miss you caught this year. What made it easy to almost happen?

Near misses are free lessons

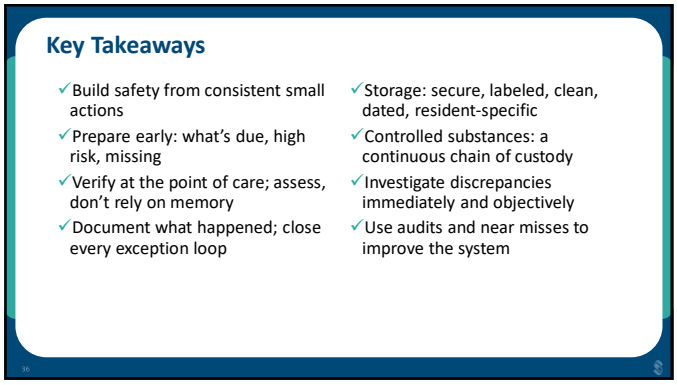
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Shift change: the oxycodone record says 18, the drawer has 17. The med aide who gave the last dose has gone home. What do you do in the next 10 minutes?
Share your answer: slido.com, code #2173256

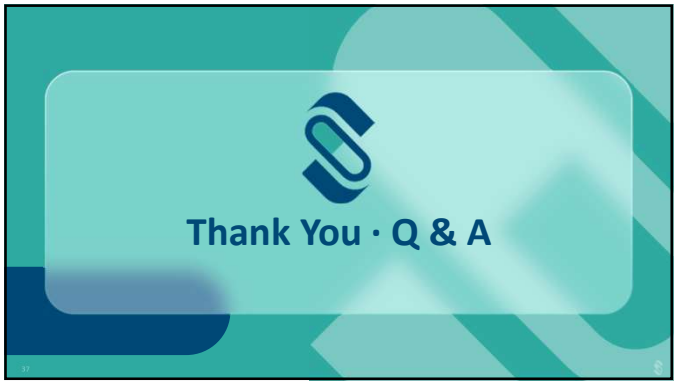
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What You Found
Recount: still 17. The MAR shows a 2 p.m. dose never signed out.
Is This Resolved?
• Likely documentation, not confirmed
• Contact the med aide
• Verify balance; correct per policy
• Notify and document
What If No MAR Entry?
• Now it's unexplained
• Secure; notify leadership and pharmacy
• Preserve records and access logs
• Follow investigation policy
Do Not
• Alter the count to "make it match"
• Delay until the next shift
• Accuse based on suspicion

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Key Takeaways
✓Build safety from consistent small actions
✓Prepare early: what's due, high risk, missing
✓Verify at the point of care; assess, don't rely on memory
✓Document what happened; close every exception loop
✓Storage: secure, labeled, clean, dated, resident-specific
✓Controlled substances: a continuous chain of custody
✓Investigate discrepancies immediately and objectively
✓Use audits and near misses to improve the system

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