Providing Licensing, Certification and Monitoring Compliance as the designee for the Department of Health (DOH), Office of Healthcare Assurance (OHCA)

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Aloha CMA and CCFFH Operators,
The information contained in this official newsletter has been reviewed and approved by DOH/OHCA. It is being distributed to all CMAs and CCFFHs.

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During inspections, CTA nurse compliance managers review documents that show persons have a current tuberculosis (TB) clearance that meets Department of Health TB Branch requirements. These requirements apply to all persons living or working in designated care or residential care facilities. You can find the requirements and forms on CTAs website under CCFFH Forms or look up the TB rules and requirements on the DOH TB website at https://health.hawaii.gov/tb/.

CTA recently confirmed with the DOH TB Branch that only MDs, APRNs, or PAs on behalf of MDs are authorized to sign the actual TB form. Registered Nurses can administer the tests and read the results but they cannot sign TB forms.

Effective immediately, all TB forms must be signed by an MD, APRN, or PA.

TB tests or screening forms must be completed each year. Documentation of test results are official documents and must never be altered. Alteration will result in enforcement action against the home operator. For example, a CCFFH cannot simply make a copy of the previous year and change the date. Dates cannot be changed/altered in any way. If any form does not appear

authentic, the CCFFH will need to prove it is authentic and CTA may confirm its authenticity with the person who signed the form whether it is a TB screening, TB Test, in-service training certificate, etc. The Office of Health Care Assurance can take enforcement action against the CCFFH including but not limited to revocation or suspension of the CCFFH certificate or issue an administrative monetary penalty.

Changes to Medication Orders

There are many reasons a clients' medication may change over the course of their care. Prescriptions may be discontinued, doses may change, and frequency of administration may decrease or increase. As part of the care team, you play an important role in making sure the client is receiving exactly what the doctor or APRN has ordered.

Tips to manage changes in medication orders:

- Accompany clients to their appointments whenever possible. You are an integral member of that client's care team to both get and relay information to the physician.
- Check office visit notes after each appointment, paying close attention to any changes in the client's medication orders. Communicate any changes in medication to the client's CMA immediately. Fax the CMA a copy of any physician visit notes as soon as possible.
- Know what each client's medication is used for. Make sure you understand the directions for each medication such as take with food or before eating, after taking pulse or blood pressure, etc., including any special storage instructions such as in refrigerator, out of sunlight, etc.
- Check discharge instructions from skilled nursing facilities, rehab centers or hospital after a client returns home. It is common for medications to change after a health event.
- Check the Medication Administration Record (MAR) at the beginning of each month to make sure it matches the prescription bottles for the medication the client is taking. Review the MAR with the Case Management RN at the time of their monthly visit. Always follow the 6 rights of medication administration. Always look at the MAR before giving every medication, compare the bottle to the MAR and document the medication being administered immediately afterwards.

- Always keep the most recent medication orders in the client's record. CTA and CMAs will review these orders to make sure they match what is being given.
- If a discrepancy is noted between the doctor's or APRN's order and the MAR, immediately alert the CMA RN to assist with clarifying the order with the doctor, APRN, or pharmacy.
- If an order changes, is discontinued, or a new medication is started, enter the new information on the MAR as delegated by the CMA RN. Make a note showing the date that the order was changed, stopped, or started. Make sure to alert the CMA RN of all medications changes as soon as possible and no more than 24 hours from when the medication changed.

The CMA RN and caregivers play an important role to double check to ensure the prescription was ordered and filled correctly.

- **Caregivers shall not remove or make changes to the medication labels** on the prescription bottles. This practice is illegal since you are not a pharmacist. If dosage or administration instructions change, get the new prescription filled as soon as possible with the most up to date prescription label. Or include the new dosage or instructions with the prescription bottle.

How to document on the MAR:

- Enter your initials instead of an "X" or a check mark on the MAR for the date and time you give the medication. It is important to know which caregiver administered each dose. Make sure to fill in at the bottom of the MAR with your full name to identify whose initials are on the MAR.
- If the client does not want to take the medication, indicate that they "refused" on the MAR. The client has the right to refuse a dose, but it is important to know when this happens and how often. Write on the back of the MAR the reason for the refusal or any missed dose.
- If you run out of a medicine, and a dose is due, it is important to note this as well on the MAR. Some medications cannot be skipped, and you should immediately notify the RN CM or the client's physician or APRN.
- If a medication is not signed for after giving the medication, a dose is missed, a wrong dose is given (either too much or too little), given by the wrong route, or the wrong medication is given (some medication names look similar and may be different by only a couple of letters), they are

considered an Adverse Event (AE) and you must complete an AE Report. The AE Report alerts the members of the care team to monitor the client for any possible negative impact of the error as well as to identify whether any additional training should occur.

Please note that Medication Errors are common in the health care industry although they can be reduced by following proper Medication Administration Protocols and by reporting when errors do occur. Failure to report a Med Error or any Adverse Event is a violation of the Hawaii Administrative Rules.